Arizona

Substance Abuse Prevention and Treatment Block Grant
(SAPT)

Community Mental Health Services Block Grant
(CMHS)

Combined Planning Application
FY 2012 - 2013

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Treatment
Center for Substance Abuse Prevention

I: State Information

State Information

Plan Year

Start Year:

2012

End Year:

2013

State DUNS Number

Number

804745420

Extension

I. State Agency to be the Grantee for the Block Grant

Agency Name

Arizona Department of Health Services

Organizational Unit

Division of Behavioral Health Services, Grants Management and Information Systems

Mailing Address

150 N. 18th Avenue; Suite 240

City

Phoenix, AZ

Zip Code

85007

II. Contact Person for the Grantee of the Block Grant

First Name

Will

Last Name

Humble

Agency Name

Arizona Department of Health Services

Mailing Address

150 N. 18th Avenue, Suite 500

City

Phoenix

Zip Code

85007

Telephone

602-542-1025

Fax

602-542-1062

Email Address

will.humble@azdhs.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

7/1/2009

To

6/30/2010

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Heather

Last Name

Ellis

Telephone

602-364-4649

Fax

602-364-4762

Email Address

Heather.Ellis@azdhs.gov

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name | Will Humble

Title | Director

Organization | Arizona Department of Health Services

Signature: _____ Date: _____

Footnotes:

Please see Application Attachments for Arizona's Chief Executive Delegation Letter

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

    a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

    b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

    c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

    d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

    a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

    b. Establishing an ongoing drug-free awareness program to inform employees about--
        1. The dangers of drug abuse in the workplace;
        2. The grantee's policy of maintaining a drug-free workplace;
        3. Any available drug counseling, rehabilitation, and employee assistance programs; and
        4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

    c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

    d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
        1. Abide by the terms of the statement; and
        2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

    e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

    f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
        1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
        2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

    g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Will Humble
Title	Director
Organization	Arizona Department of Health Services

Signature: _____   Date: _____

Footnotes:

Please see Application Attachments for Arizona's Chief Executive

I: State Information

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

   I. FORMULA GRANTS TO STATES, SECTION 1921

  II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922

 III. INTRAVENOUS DRUG ABUSE, SECTION 1923

 IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

  V. Group Homes for Recovering Substance Abusers, Section 1925

 VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

 VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

 IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

  X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

 XI. Restrictions on Expenditure of Grant, Section 1931

 XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

XIV. Requirement of Reports and Audits by States, Section 1942

XV. ADDITIONAL REQUIREMENTS, SECTION 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Arizona will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name	Will Humble
Title	Director
Organization	Arizona Department of Health Services

Signature: _____ Date: _____

Footnotes:

Please see Application Attachments for Arizona's Chief Executive
Delegation Letter

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [CMHS]

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Arizona agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Will Humble
Title	Director
Organization	Arizona Department of Health Services

Signature: _____ Date: _____

Footnotes:

Please see Application Attachments for Arizona's Chief Executive Delegation Letter

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations
Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

**Background and Structure of the Service Delivery System**

Established in 1986 by Arizona Revised Statute (A.R.S.) §36-3402, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS, or Division) is authorized and responsible for providing coordination, planning, administration, regulation and monitoring of all facets of the State's public behavioral health system. The Division serves as both the Single State Authority (SSA) for the Substance Abuse Prevention and Treatment Block Grant, as well as the State Mental Health Authority (SMHA) for the Community Mental Health Services Block Grant (SAPT/CMHS). In this capacity, ADHS/DBHS has numerous responsibilities, including:

- Administering a comprehensive, regionalized, behavioral health system of community-based prevention, intervention, treatment and rehabilitative services for individuals and families;
- The application, execution and oversight of numerous federal grants providing funding for mental health, substance abuse and prevention services, as well as workforce development training initiatives;
- Partnering with other state agencies to improve service delivery for shared clients, including children and adults in the correctional, criminal justice, primary and public health care, education, child welfare, and developmental disability systems;
- Contracting with the Arizona Health Care Cost Containment System (AHCCCS) to plan, administer, and monitor behavioral health services funded through Medicaid;
- Partnering with county and city municipalities to provide necessary services within those communities;
- Providing care to individuals enrolled within other state programs, including the Arizona Long Term Care System for those with Developmental Disabilities (DD-ALTCS), and Child Protective Services, and;
- Operating the Arizona State Hospital (ASH), accredited by the Joint Commission, to provide long-term psychiatric care to the most seriously mentally ill Arizonans.

The Division contracts with Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) to administer integrated managed care delivery services in six distinct geographic service areas (GSAs) throughout the State (please see map, next page). The T/RBHAs, in return, subcontract with various prevention and treatment providers within their respective regions to ensure a full spectrum of services are available to behavioral health consumers. This regionalized system allows local communities to provide services in a manner appropriate to meet the unique needs of individuals and families in those areas.

The Division of Behavioral Health Services has direct oversight authority of the programmatic and fiscal activities of the T/RBHAs and, in turn, the T/RBHAs are required by contract to monitor their treatment providers. Monitoring for contract compliance, adherence to Medicaid regulations, fiscal accounting, program design, delivery, and effectiveness, occurs in a structured manner at least annually – with some oversight procedures conducted each fiscal quarter, or on a monthly basis, by Division staff. Additionally, the Division regularly contracts with outside consultants for independent system-wide, or population-specific, evaluations, as required by Federal regulations.

The T/RBHAs are required to maintain and operate a comprehensive network of behavioral health providers that deliver prevention, intervention, treatment and rehabilitative services to a variety of populations, including: Adults with a Serious Mental Illness (SMI); Adults with General Mental Health Disorders (GMH); Adults with Substance Use Disorders (SUD/SA), and; Children and Adolescents – including those with a diagnosed Serious Emotional Disturbance (SED).
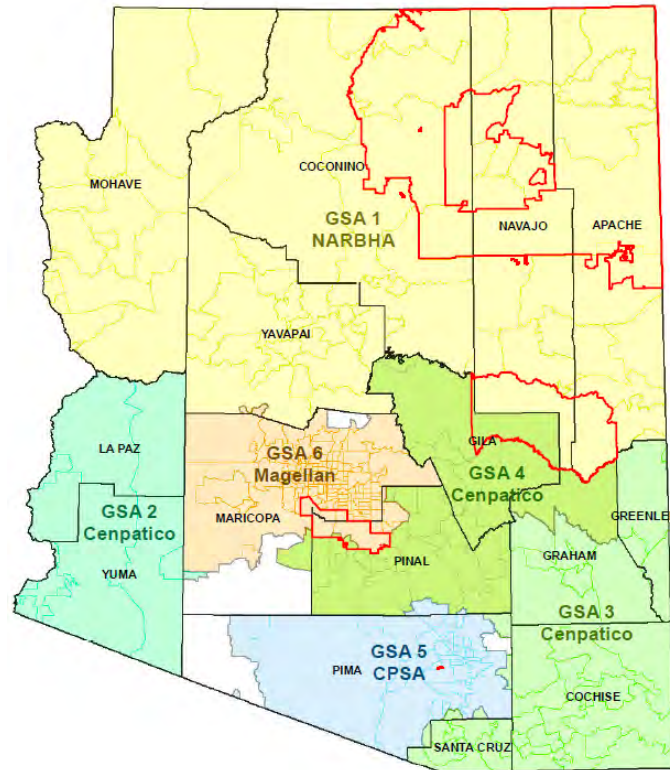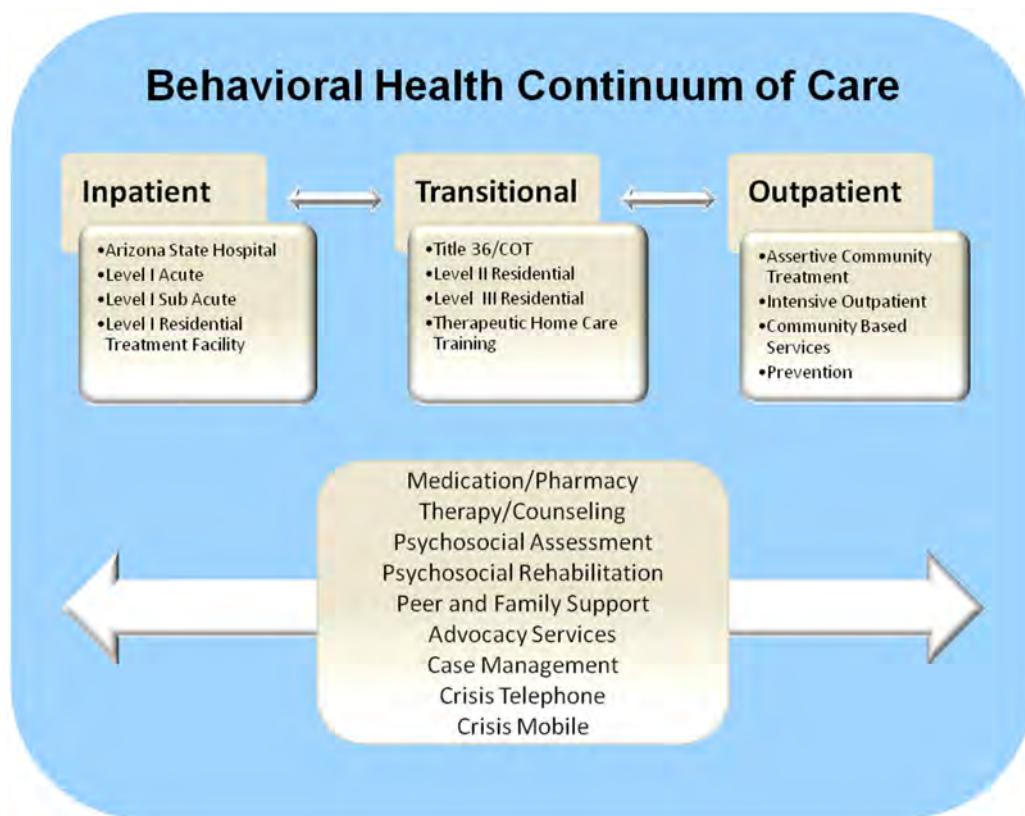
Continuum of Care

Arizona has been recognized as a leader in the public sector behavioral health field in its managed care approach to service delivery. ADHS/DBHS focuses its efforts and energies toward providing leadership in activities designed to integrate and adapt the behavioral health system to more effectively meet the needs of those we serve.

ADHS/DBHS endorses a comprehensive, person/family supportive, and recovery oriented system of care for people in need of publicly funded behavioral health treatment. To ensure this vision of recovery is achieved in a manner that promotes a *good and modern* mental health and addiction system, the Division maintains a firm commitment to increasing access to care and reducing barriers to treatment; collaborating with the greater community; cultural competency; effective innovation and program evaluation, and; emphasizing consumer and family involvement in an individual's treatment program.

The Division offers a wide range of behavioral health services and the continuum of care spans from services that are more restrictive to those that are less restrictive. Generally speaking, services can be grouped into seven categories: Crisis, Inpatient, Residential, Outpatient, Medical/Pharmacy, Support, and Rehabilitation services (please see Continuum of Care diagram, next page). Furthermore, The Division works collaboratively with RBHAs, TRBHAs and Tribal Nations to ensure that this full continuum is available in all urban and rural areas of Arizona, and is capable of sufficiently addressing the disparate needs of various groups, including racial and ethnic minorities, the LGBTQ community, and other historically underserved populations.[1]

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[1] The Division has a robust framework around providing culturally competent care and outreach for historically underserved persons; a thorough review of the Division's Cultural Competency programs and initiatives is included in the next section of this application.

Behavioral Health Continuum of Care

Inpatient
- Arizona State Hospital
- Level I Acute
- Level I Sub Acute
- Level I Residential Treatment Facility

Transitional
- Title 36/COT
- Level II Residential
- Level III Residential
- Therapeutic Home Care Training

Outpatient
- Assertive Community Treatment
- Intensive Outpatient
- Community Based Services
- Prevention

Medication/Pharmacy
Therapy/Counseling
Psychosocial Assessment
Psychosocial Rehabilitation
Peer and Family Support
Advocacy Services
Case Management
Crisis Telephone
Crisis Mobile

Crisis services are available to anyone and include access to 24/7 telephone hotlines, crisis mobile response teams, screening, assessment, evaluation and short-term inpatient stabilization services. These critical services offer both a front door into the behavioral health system and a safety-net for persons at grave risk of harm. Without a crisis system, police, fire and emergency responders would be left to deal with situations that, in the vast majority of cases, do not involve criminal behavior or public safety issues.

Inpatient Treatment Services are designed to provide continuous treatment to persons experiencing acute and severe behavioral health or substance abuse symptoms. Level I Acute, Level I Sub-Acute, and Level I Residential Treatment Center settings refer to the behavioral health license and are based on the level of supervision provided on site.

Residential Services are those provided in a structured treatment setting with 24-hour supervision from an on-site or on-call behavioral health professional for persons who do not require on-site medical services or who need protective oversight. Level II, Level III, and Therapeutic Home Care Training refer to the behavioral health license and are based on the level of supervision provided on site.

Outpatient Treatment Services are typically provided at a clinic or in the community and include assessment, evaluation, screening, group and individual counseling and other services that help reduce symptoms and improve or maintain functioning. The vast majority of behavioral health recipients are served in their local communities in an outpatient setting, which is significantly less-costly than inpatient care, or placement within a residential facility.

Medical/Pharmacy Services such as prescription medications to prevent, stabilize or reduce symptoms of a behavioral health condition. This also includes medical tests ordered for diagnosis, screening or monitoring of a behavioral health condition, i.e. blood and urine tests. Ongoing medical assessment and management services to review the effects of medications and to adjust the type and dosage of prescribed medications are also included here.

Support Services include a wide variety of activities to help persons with mental illness live independently and remain productive members of the community. This includes case management, peer support, family support and respite care, housing support, transportation, and personal care services.

Peer and family support is an especially critical service because it accomplishes two very important objectives. First, because peers have been recipients of behavioral health services, they are able to relate to persons with mental illness in a way that professionals cannot. Second, peers and family members are trained and employed by provider agencies including agencies that are themselves run by peers or family members. Peers or family members who provide services offer unique support to recipients because they share personal experience with substance abuse and or mental illness themselves or in their families. This type of relationship often takes more of a self-help/recovery approach since the peer or family worker can serve as an example of a person who has progressed in managing the behavioral health or substance abuse challenges in their lives. Accordingly, the Behavioral Health System employs over 440 Peer and Family Support Professionals.

Rehabilitation Services include teaching of independent living, social and communication skills, health and wellness promotion, and ongoing support to maintain employment—most often provided in an outpatient setting.

Service Capacity and Network Sufficiency
ADHS/DBHS utilizes a Logic Model for Network Sufficiency to review multiple data sources in an effort to identify patterns, gaps, trends, and service demands. The analysis of this data assists in determining the network capacity, configuration of needs and service gaps, and assessment of essential minimum network requirements. The Logic Model provides a framework for analysis and is one factor in determining essential minimum network requirements. Below is an overview of the complete Network Analysis process:
- Ongoing review and monitoring of T/RBHAs' utilization data and single case agreements to identify barriers and the need for network expansion of contracted providers
- Ongoing review and monitoring of T/RBHAs' and state level Complaint/Issue Resolution Data to identify any potential network gaps in behavioral health services or providers
- Ongoing statewide on-site T/RBHA/Provider validation activities to assess network availability of services, quality of programs, and facility tours.
- Ongoing statewide review and monitoring of T/RBHAs contract reporting requirements to network sufficiency enhancements and or reductions, including:
  - Assessment and tracking of provider enhancements and reductions.
  - Monitoring the continuity of care for consumers
  - Identification of potential network sufficiency needs.
- Quarterly review of T/RBHA utilization data by Covered Service category and Sub-Category.

- Annual T/RBHA Geo-Mapping analysis and monitoring to assess statewide networks for access to certain provider types using geo-mapping technology.
- Annual review and monitoring of the Adult Consumer Satisfaction Survey to assess statewide independent feedback from Medicaid-eligible adults receiving services through the RBHAs. This monitoring activity measures member perception of behavioral health services in relation to the following domains:
  - General Satisfaction
  - Access to Services
  - Service Quality/Appropriateness
  - Participation in treatment
  - Outcomes
  - Cultural Sensitivity
  - Improved functions
  - Social Connectedness
- Annual and ongoing review and monitoring of the T/RBHAs' network capacity for Behavioral Health Professionals (Prescribers). This monitoring activity involves review of Complaint/Issue Resolution data, Network Provider Notification Changes in relation to established Network Inventory data and Minimum Network Standards.
- Quarterly review and monitoring of the T/RBHAs' Adult & Child System of Care Plan to assess identified network development and/or enhancement needs. The plan is evaluated by DBHS Adult System of Care staff and monthly meetings are held with each T/RBHA to discuss progress, barriers, and priorities for the following quarter. DBHS provides technical assistance to the T/RBHAs, as needed, related to regional network development activities.

The review of the above-mentioned data also includes an analysis of any trends observed in enrollment, eligibility, and penetration rates specific to each RBHA.[2] The outcome of this analysis determines whether the current network is sufficient for each RBHA. Following this review process, meetings occur with each RBHA, during which this information is discussed, and possible network needs are identified. In response to ADHS/DBHS' findings, each RBHA develops a network report and plan, which is extensively reviewed by DBHS staff. These plans are revised as necessary to address all concerns identified during the review process, prior to implementation of any action.

Annual Network Inventory
Once the aforementioned review has been completed, ADHS/DBHS synthesizes the results and compiles an annual inventory of the available facility capacity by level of care across the service delivery network. Doing so allows ADHS/DBHS to identify weaknesses within the continuum of care and may prompt further gap analyses. The most recent network inventory, completed in April, 2011, is summarized in the table on the next page.

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[2] Enrollment trends and numbers served are discussed in the next section of this application

Facility Type	RBHA - GSA[3]	Number Serving Each Population[4,5]		
		Child	Adult GMH/SA	Adult SMI
Outpatient Clinic	NARBHA	40	47	40
	Cenpatico 2	15	18	19
	Cenpatico 3	28	8	4
	Cenpatico 4	40	36	32
	CPSA	51	70	70
	Magellan	48	96	136
	Arizona	**222**	**275**	**301**
Opiate / Methadone Clinic	NARBHA	0	3	3
	Cenpatico 2	0	2	2
	Cenpatico 3	0	1	1
	Cenpatico 4	0	4	4
	CPSA	0	7	7
	Magellan	0	14	14
	Arizona	**0**	**31**	**31**
Level I Residential	NARBHA	1	0	0
	Cenpatico 2	0	0	0
	Cenpatico 3	1	0	0
	Cenpatico 4	5	0	0
	CPSA	0	0	0
	Magellan	3	0	0
	Arizona	**10**	**0**	**0**
Level II Residential	NARBHA	3	5	5
	Cenpatico 2	1	1	2
	Cenpatico 3	9	3	6
	Cenpatico 4	8	9	7
	CPSA	6	32	32
	Magellan	12	39	66
	Arizona	**39**	**89**	**118**
Level III Residential	NARBHA	0	3	3
	Cenpatico 2	0	0	0
	Cenpatico 3	12	0	0
	Cenpatico 4	0	0	0
	CPSA	5	0	5
	Magellan	5	8	11
	Arizona	**22**	**11**	**19**
Rural Substance Abuse Transitional Center	NARBHA	0	4	4
	Cenpatico 2	0	1	1
	Cenpatico 3	0	1	0
	Cenpatico 4	0	1	1
	CPSA	0	0	0
	Magellan	0	0	0
	Arizona	**0**	**7**	**6**
Level I Sub-acute Facility	NARBHA	0	1	1
	Cenpatico 2	0	1	1
	Cenpatico 3	0	4	5
	Cenpatico 4	0	1	1
	CPSA	1	0	5
	Magellan	0	7	7
	Arizona	**1**	**14**	**20**

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[3] Network capacity for the Tribal Authorities was not readily available at the time of this application's submission.

[4] Reflects the number of contracted facilities located within each RBHA's Geographic Service Area. In order to ensure adequate capacity, RBHAs will also contract with providers located in other GSAs.

[5] Some facilities may be included under more than one population group, as providers often serve both adult populations and, in the more rural areas of the state, children and adolescents within the same physical facility.

Discussed in more detail later in this application, the Division and its contracted RBHAs maintain a firm commitment to partnering with Peer and Family Run Organizations and increasing the utilization of the crucial support services provided by these organizations. As of August, 2011, there were nine Peer-Run, and seven Family-Run, Organizations operating within the public behavioral health system. The below table illustrates their distribution.

RBHA – GSA	Peer Run Organizations	Family Run Organizations
NARBHA	1	1
Cenpatico 2	0	1
Cenpatico 3	1	1
Cenpatico 4	0	1
CPSA	3	1
Magellan	4	2

Eligibility for Behavioral Health Services
The continuum of care broadly describes services and treatment modalities available to all Medicaid-eligible behavioral health recipients, including those with a General Mental Health Disorder, a Serious Mental Illness, a Serious Emotional Disturbance, and/or a Substance Use Disorder. With the exception of limitations placed on residential care, and dependent on available funding, non-Medicaid eligible recipients with a diagnosed Substance Use Disorder (SUD) have access to the full service array as needed to treat their dependence.[6]

Non-Medicaid eligible Adults with a Serious Mental Illness receive a limited benefit package due to recent budget reductions resulting from the economic crisis. Specifically, these individuals have access to the following covered services:
- A generic medication formulary. For those members who prefer brand name medications, these medications can be prescribed, but they are not a covered benefit; costs associated with the use of brand medication are the responsibility of the member. RBHAs are encouraged to access pharmacy prescription assistance programs to obtain no-cost or reduced-cost brand name medications.
- Medically necessary laboratory services as currently available in the ADHS/DBHS Covered Behavioral Health Services Guide.
- Psychiatric assessments for newly enrolled Non-Medicaid eligible SMI members, or when a new or different medical professional assumes responsibility for treatment of the member.
- Psychiatric follow-up appointments for medication management.
- Telephone contact by prescribing medical professionals (MD, DO, NP, PA) or nursing
- (RN, LPN) staff.
- Nursing (RN, LPN) assistance for prescribing medical professionals and medication administration.
- Interpretation services.

All other services listed in the ADHS/DBHS Covered Behavioral Health Services Guide, such as transportation, residential and inpatient care, and case management are not covered for this population. If a member wants any of these services, payment is the responsibility of the member or another third-party payer (Medicare, VA, etc.) if available. In addition, intensive service models, including Assertive Community Treatment (ACT) and Intensive Recovery Teams (IRT) are not available.

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[6] SAPT Funded Room and Board / Residential services are limited to Children/Adolescents with a Substance Use Disorder (SUD), and adult priority population members (pregnant females, females with dependent child(ren), and intravenous drug users with a SUD).

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system
Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

ADHS/DBHS utilizes a number of data feeds, surveys, systemic evaluations, as well as stakeholder forums, to determine statewide need for services and works in tandem with the T/RBHAs to ensure that efficient resource allocation permits system capacity to correlate with service demand. Although effective, because of the multiple data sources utilized, this process is difficult to manager and ADHS/DBHS is working to implement a new methodology for assessing prevention, subvention, and treatment needs for both Mental Health and Substance Use Disorders. ADHS/DBHS anticipates this new process will be formalized sometime in late Fiscal Year 2012 and will be used to direct state priority initiatives outlined in the Fiscal Year 2014 Block Grant Planning Section (due April, 2013). This section details the current instruments and methodology used for assessing service needs; the identified strengths, needs and programmatic initiatives within Arizona's service delivery system; the Systems of Care plans, and; the anticipated impact Healthcare Reform may have on the public behavioral health system.

Substance Abuse – Prevention and Treatment Services for Adults and Children

The National Survey on Drug Use and Health (NSDUH), prepared by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Applied Studies (OAS), provides the underlying methodology used by ADHS/DBHS to quantify substance abuse treatment need in Arizona.[1] On an annual basis, prevalency information from the NSDUH is compared to census data, both actual and estimated, for the State of Arizona. Formerly, this was done to comply with Forms 4 and 5 of the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the results outlined treatment need based on race/ethnicity, gender, and age group for the State as a whole, and then for each county and/or sub-state planning area.

The most recent review of this information, as seen on the following page, notes that 606,812 individuals (approximately 9.2 percent of the population) were in need of treatment for an illicit drug or alcohol use problem. Additionally, of the number needing treatment, 9.9 percent would actively seek treatment. These percentages were applied to the Population for each sub-state planning area to determine the total number in need of treatment services – approximately 60,000 individuals seeking treatment for a substance use disorder, or dependence, statewide. Unfortunately, the NSDUH does have a significant shortcoming in that it does not identify substance use prevalence for individuals under the age of 12 – making it exceedingly difficult to determine true need for services within this age group without the use of a more specific, State-tailored, assessment method.

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[1] Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4586 Findings). Rockville, MD.

Planning Area	Population	Total Population in Need		Number of IVDUs in Need		Number of Women in Need		Prevalence of Substance-related Criminal Activity		Incidence of Communicable Diseases (per 100,000)		
		Needing Treatment Services	That Would Seek Treatment	Needing Treatment Services	That Would Seek Treatment	Needing Treatment Services	That Would Seek Treatment	Number of DWI Arrests	Number of Drug-related Arrests	Hepatitis B	AIDS	Tuberculosis
Apache	70,591	6,494	643	127	23	2,254	223	438	367	8	28	6
Coconino	129,849	11,946	1,183	234	42	4,147	411	805	675	12	67	4
Mohave	194,825	17,924	1,774	351	62	6,222	616	1,208	1,013	18	62	2
Navajo	112,975	10,394	1,029	203	36	3,608	357	700	587	12	27	4
Yavapai	215,686	19,843	1,964	388	69	6,888	682	1,337	1,122	4	46	2
La Paz	20,012	1,841	182	36	6	639	63	124	104	15	70	15
Yuma	196,972	18,121	1,794	355	63	6,290	623	1,221	1,024	6	44	13
Cochise	129,518	11,916	1,180	233	41	4,136	409	803	673	11	57	1
Graham	37,045	3,408	337	67	12	1,183	117	230	193	11	38	3
Greenlee	8,041	740	73	14	3	257	25	50	42	12	37	0
Santa Cruz	43,771	4,027	399	79	14	1,398	138	271	228	5	50	0
Gila	52,199	4,802	475	94	17	1,667	165	324	271	11	29	0
Pinal	340,962	31,369	3,105	614	109	10,889	1,078	2,114	1,773	17	88	11
Pima	1,020,200	93,858	9,292	1,836	327	32,581	3,226	6,325	5,305	13	114	4
Maricopa	4,023,132	370,128	36,643	7,242	1,289	128,483	12,720	24,943	20,920	25	108	4
Arizona	6,595,778	606,812	60,074	11,872	2,113	210,643	20,854	40,894	34,298	20	98	5

Age Band	Population	White		African American		Native Hawaiian / Other Pacific Islander		Asian		American Indian / Alaska Native		Multiracial		Not Hispanic or Latino		Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
10 - 14 Years	468,300	12,198	13,419	566	623	31	35	377	415	707	778	409	450	11,161	12,278	4,559	5,015
15 - 19 Years	448,513	20,750	10,594	963	491	53	27	642	328	1,203	614	695	355	18,985	9,693	7,755	3,959
20 - 24 Years	441,917	20,445	10,438	948	484	53	27	632	323	1,186	605	685	350	18,706	9,551	7,641	3,901
25 - 29 Years	501,279	23,191	11,841	1,076	549	60	31	717	366	1,345	687	777	397	21,219	10,833	8,667	4,425
30 - 34 Years	455,109	21,055	10,750	977	499	54	28	651	332	1,221	623	705	360	19,265	9,836	7,869	4,017
35 - 39 Years	448,513	20,750	10,594	963	491	53	27	642	328	1,203	614	695	355	18,985	9,693	7,755	3,959
40 - 44 Years	448,513	20,750	10,594	963	491	53	27	642	328	1,203	614	695	355	18,985	9,693	7,755	3,959
45 - 49 Years	448,513	20,750	10,594	963	491	53	27	642	328	1,203	614	695	355	18,985	9,693	7,755	3,959
50 - 54 Years	408,938	18,919	9,659	878	448	49	25	585	299	1,097	560	634	324	17,310	8,838	7,070	3,610
55 - 59 Years	362,768	16,783	8,569	779	398	43	22	519	265	973	497	562	287	15,356	7,840	6,272	3,202
60 - 64 Years	316,597	14,647	7,478	680	347	38	19	453	231	849	434	491	251	13,401	6,842	5,474	2,795
65 - 69 Years	244,044	11,291	5,764	524	267	29	15	349	178	655	334	378	193	10,330	5,274	4,219	2,154
70 -74 Years	197,873	9,154	4,674	425	217	24	12	283	145	531	271	307	157	8,376	4,276	3,421	1,747
75 - 79 Years	184,682	8,544	4,362	396	202	22	11	264	135	495	253	286	146	7,817	3,991	3,193	1,630
80 - 84 Years	125,320	5,798	2,960	269	137	15	8	179	92	336	172	194	99	5,305	2,708	2,167	1,106
85 Years +	98,937	4,577	2,337	212	108	12	6	142	72	265	136	153	78	4,188	2,138	1,711	873
Total	5,599,816	249,604	134,629	11,580	6,246	643	347	7,720	4,164	14,474	7,807	8,363	4,511	228,375	123,178	93,280	50,312

The Substance Abuse Epidemiology Workgroup, originally created in 2004 as requirement of the Strategic Prevention Framework State Incentive Grant (SPF SIG), and later formalized as a subcommittee of the Arizona Substance Abuse Partnership (ASAP), has a membership roster including statisticians, data analysts, academics, holders of key datasets, and other key stakeholders from various state and federal agencies, tribal entities, private and non-profit substance abuse-related organizations, and universities.[2] This group is tasked with providing communities, policymakers and local, state and tribal officials with data on the use of alcohol and illicit, over-the-counter, and prescription drugs to inform their substance abuse prevention and intervention strategies. The primary responsibilities of the Epidemiology Workgroup include:

- Compiling and synthesizing information and data on substance abuse and its associated consequences and correlates, including mental illness and emerging trends, through a collaborative and cooperative data-sharing process;
- Assessing substance abuse treatment service capacity in Arizona and detail gaps in service availability;
- Serving as a resource to the Arizona Substance Abuse Partnership and member agencies to support data-driven decision-making that makes the best use of the resources available to address substance abuse and related issues in Arizona; and
- Identifying data gaps and address them in order to provide Arizona with a comprehensive picture of substance abuse in the state.

To this extent, the Epidemiology Workgroup develops a bi-annual Substance Abuse Profile for the State. In return, ADHS/DBHS uses this profile to help assess need for substance abuse prevention and treatment.[3]

ADHS/DBHS also relies on the results of numerous qualitative surveys to determine need and directs resources accordingly. These surveys are critical to identifying potential service gaps as they are able to capture the human component, most notably, the effect that a lack of services can have on a community that a quantitative analysis cannot adequately determine. These surveys, as well as other tools for assessing need, are detailed in the tables on the following pages.

The NSDUH analysis and the Epidemiologic Profile reinforce the findings of Arizona's qualitative data feeds. When reviewed in concert, and used in conjunction with other special reports to assist in understanding the statewide distribution of need, demand, and capacity for substance abuse treatment, these studies generally support the resource allocation formulary used by the Division for non-Medicaid populations. Specifically, they disclose that:

- There is little geographic variation in the prevalence of need for substance abuse treatment;
- Demand for treatment varies most by population size, with denser areas of the state experiencing the highest demand for treatment;
- Certain high-risk groups do exist, including young adults, women in the Northern Arizona region;
- Statewide, treatment capacity is insufficient to meet the needs of the general population;
- Alcohol is Arizona's most prevalently used substance and carries the greatest economic burden, and;
- Prescription drug abuse and related consequences have been increasing for the past five years.

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[2] For more information on the Arizona Substance Abuse Partnership, please see Section N of this application.

[3] The most recent state epidemiological profile is available at http://gocyf.az.gov/SAP/PR_SAEP09.asp

Tool	Administration Method	Frequency of Administration	Theme	Important Findings
ADHS Title V needs assessment Affordable Health Care Act Maternal, Infant, and Early Childhood Home Visiting Program; Arizona Needs Assessment 2010	Includes a review of epidemiological data combined with community input.	Once	Behavioral and physical needs of women	Nearly one-in-five women age 18-44 years had problems dealing with depression, stress, and/or emotions during the past month. Intentional injury-related mortality, (suicide and homicide) declined during the past decade for women of reproductive age.
Arizona Vital Statistics http://www.azdhs.gov/plan/report/avs/avs09/index.htm		Statistics are updated annually	Morbidity and mortality of Arizonans	There was a 16% increase in the age-adjusted rate of inpatient hospitalizations related to self-inflicted injuries, from 2005 to 2009. A significant increase in unintentional poisonings between 2004 and 2008 contributed to an increase in unintentional injury related mortality. In 2008, Arizona experienced steep increase in the number of people presenting to EDs for overdoses of prescription drugs. Additionally, Arizona is experiencing a rise in deaths due to substance abuse.
Arizona Youth Survey http://www.azcjc.gov/ACJC.Web/Pubs/Home/Arizona_2 010_Report_Final_02242011.pdf	8th, 10th, and 12th grade students	Every 2 years	Substance use, risk and protective factors	Alcohol is the most prevalently used substance for youths in AZ. In 2010 there was a dramatic statewide rise in 30 day use of Marijuana among Arizona 8th, 10th, and 12th grade students.
St Luke's Health Initiative 2010 Arizona Health Survey. http://www.arizonahealthsurvey.org/wp-content/uploads/2011/05/ahs-2010-veterans-May11.pdf	Adults	Annually	Substance Abuse & Mental Health needs of Arizonans	Veterans have higher rates of alcohol use than general public
AZHEIN (2010) Survey of Arizona university Students *Unpublished report*	Students enrolled in Arizona Universities	Annually	Substance use behaviors, consequences, & contributing factors	Alcohol is the most commonly used substance among Arizona college students. LGBTQ students use alcohol and other substances at a greater rate than other students.
Community Health Centers of Arizona Integration Survey *Unpublished report, January 2011*	Survey of behavioral health and community health clinics	Once	Integration between behavioral and physical health services & the use of SBIRT	None of the community health centers in Northern Arizona currently use SBIRT. Nor do they use any of the standardized substance abuse assessment tools. Low use of these tools may be due to Arizona's waiver to reimburse medical providers for screening and brief intervention.

Tool	Administration Method	Frequency of Administration	Theme	Important Findings
Emergency Department (ED) Initiative Assessment Finding Report *Unpublished report, September, 2010*	Survey data from 38 emergency departments statewide.	Once	ED suicide and substance abuse prevalence rates, as well as recommendations for interventions to serve these patients.	Behavioral health consultation and referral to local community resources are the most common interventions for suicide and substance abuse-related emergency department cases. Medical staff recommended that community resource options for low-income and uninsured patients increase and that referral guides for resources are made readily available. Screening for substance abuse and suicide was identified as a resource need, and was recommended for integration in emergency department nursing assessments.
Living well with disabilities community needs assessment *Unpublished report, Fall, 2010*	Comprehensive assessment of the needs of people with disabilities in Maricopa County collected through 1 focus group, 6 key informant interviews.	Every 3 years	Substance abuse and other behavioral health issues	Within both the civilian and the veteran populations there are signs of growing abuse of prescription medications, particularly medications for pain relief and behavioral health issues such as depression and acute anxiety. There is a greater need for integration of medical and behavioral health services.
Youth Risk Behavior Survey (YRBS)	Survey for Arizona students in grades 9 through 12	Every 2 years	Physical health, substance use, suicide ideation and suicide attempts.	17.3% of students in Arizona said that they had seriously considered suicide, 12.1% said they had made a plan to commit suicide, and 9.5% said they had actually attempted to commit suicide within the last 12 months. Females are at higher risk of suicidal ideation and attempted suicide. Youth residing in Arizona are significantly more likely to engage in binge drinking, although the proportion of students in Arizona reporting this behavior declined significantly from 34.8 percent in 2003 to 27.4 percent in 2009.

Tobacco Enforcement

A recently issued report by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicated that the rate of tobacco use among individuals ages 12 and over has declined in Arizona since 2007.[4] The 2011 SYNAR Report, submitted to SAMHSA in December, 2010, detailed the State's youth tobacco access laws and the results of the most recent tobacco enforcement inspections. The SYNAR inspection results indicated that 44 of 746 (5.9%) attempted tobacco purchases made by minors were successful – a slight increase from the previous year's rate of 4.8%, yet still well below both the federally established Retailer Violation Rate (RVR) of 20%, and the national rate of 9.3%.[5]

The State has identified several challenges pertaining to enforcing Youth Tobacco Laws; namely, while the Office of the Attorney General conducts the majority of tobacco enforcement inspections, actual citations may only be issued by local law enforcement entities. Due to the economic downturn, many law enforcement agencies in Arizona have experienced workforce reductions, resulting in fewer officers available to participate in tobacco enforcement activities.

Furthermore, between 2009 and 2010, there was a 16% decline in the number of businesses selling tobacco products – which, if not accounted for, could skew the findings of future inspection results. To compensate for this, ADHS is now placing phone calls to as many businesses as possible, prior to SYNAR inspections, to verify the existence of the vendor, their location, and that the vendor continues to sell tobacco products.

Finally, youth tobacco access laws do not provide for fines for the actual vendors, only the clerk making the sale. However, in the City of Tucson, a tobacco license may be revoked as a penalty for selling to minors; otherwise, penalties for sales are minimal. To resolve this issue, the Division of Behavioral Health has submitted recommended wording to the State Legislature in an effort to amend the laws.

Arizona will submit the Fiscal Year 2012 SYNAR Report on or before December 31st, 2011, pursuant to the authorizing legislation found in 42 U.S.C. §300x-26.

Mental Health Prevalency – Adults and Children

The need for mental health treatment for both the adult and child/adolescent populations is established primarily through the application of prevalency rates provided by the National Association of State Mental Health Directors Research Institute, Inc. (NRI). This data has been provided to the States in previous years and used exclusively to estimate the number of adults with a Serious Mental Illness (SMI), and children with a Serious Emotional Disturbance (SED) when developing the annual Community Mental Health Services (CMHS) Block Grant.

NRI updates the estimates of adults with SMI, and children with SED, using the federal estimation methodologies developed by the Center for Mental Health Services. For 2009, the adult with serious mental illness rate was defined as 5.4% of the adult civilian population for each state.[6]

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[4] Substance Abuse and Mental Health Services Administration, *State Estimates of Substance Use and Mental Disorders from the 2008-2009 National Surveys on Drug Use and Health*, NSDUH Series H-40, HHS Publication No. (SMA) 11-4641. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011 (page 8).

[5] FY 2010 Annual SYNAR Reports – Youth Tobacco Sales; http://store.samhsa.gov/shin/content//SYNAR-11/SYNAR-11.pdf

[6] 2009 prevalency data for the Adult SMI and Child SED populations was the most recently available information at the time of application's drafting.

Adult SMI Prevalence

Civilian Population Age 18+ Population 2009[7]	Civilian Population with SMI (5.4%)	Lower Limit of estimate (3.7%)	Upper Limit of estimate (7.1%)
4,652,197	251,218	172,131	330,305

Adult SMI Calculation Method:
Column 1: Civilian Population Aged 18 and Over in 2009
Column 2: Civilian Population with SMI (5.4% of adults age 18+)
Column 3: Lower Limit of Estimate (5.4% - 1.96(.8673)): 95% confidence bound
Column 4: Upper Limit of Estimate (5.4% + 1.96(.8673)): 95% confidence bound

Child SED Prevalence[8]

2009 Population of Youth Aged 9 to 17[5]	Level of Functioning Score = 50		Level of Functioning Score = 60	
	Lower Limit	*Upper Limit*	*Lower Limit*	*Upper Limit*
814,971	57,048	73,347	89,647	105,946

Child SED Calculation Method:
Column 1: 2009 Estimated Civilian Population Aged 9-17
Column 2: Lower Limit of Estimate
Column 3: Upper Limit of Estimate
Column 4: Lower Limit of Estimate
Column 5: Upper Limit of Estimate

It is important to note that these estimates are an attempt to quantify the overall statewide prevalency for adults with a Serious Mental Illness and children with a Serious Emotional Disturbance, regardless of the individuals' true need for services or the likelihood they would seek treatment with the *public* behavioral health system. Many individuals in need of mental health care receive treatment outside of the public system and are covered by private insurance or some other third-party payment source; therefore, it should not be expected that the number of individuals estimated to have an SMI or SED would equal the number enrolled and served by the public behavioral health system. Accordingly, in fiscal year 2010, the Division of Behavioral Health Services enrolled and served 41,928 adults with a Serious Mental Illness (27.4% of all enrolled adults) and 16,310 children with a Serious Emotional Disturbance (26% of all enrolled children).

Assessing the Overall Enrollment Population
Collecting and reviewing past years' behavioral health enrollment data in comparison to available needs assessment information allows the Division to identify areas of concern, including underserved populations and other potential service disparities. In this respect, enrollment data is extracted from the ADHS/DBHS' Client Information System (CIS) upon the close of each state fiscal year and evaluated on the statewide aggregate and sub-state planning levels, with a specific focus on the distribution of client demographics such as age, race, ethnicity, and gender across the service delivery network.[9]

In FY 2010 ADHS/DBHS provided behavioral health services to over 214,500 individuals. This represented an enrollment increase of 5.2%, compared to FY 2009. Most of the increase was found in children, and adults with a General Mental Health (GMH) disorder. The graph on the next page details enrollment changes from state fiscal year 2008 through 2010 by behavioral health category; additionally, the following two tables show the regions where these persons were enrolled in FY 2010 and provide basic demographic information for these individuals.

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[7] U.S. Census Bureau, 2005-2009 American Community Survey.

[8] U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement (Last revised: September 2009); estimates are tied to the child poverty rate.

[9] Consumer Enrollment and Demographic data is available in October for the preceding state fiscal year.

Enrollment by Behavioral Health Category
FYs 2008-2010
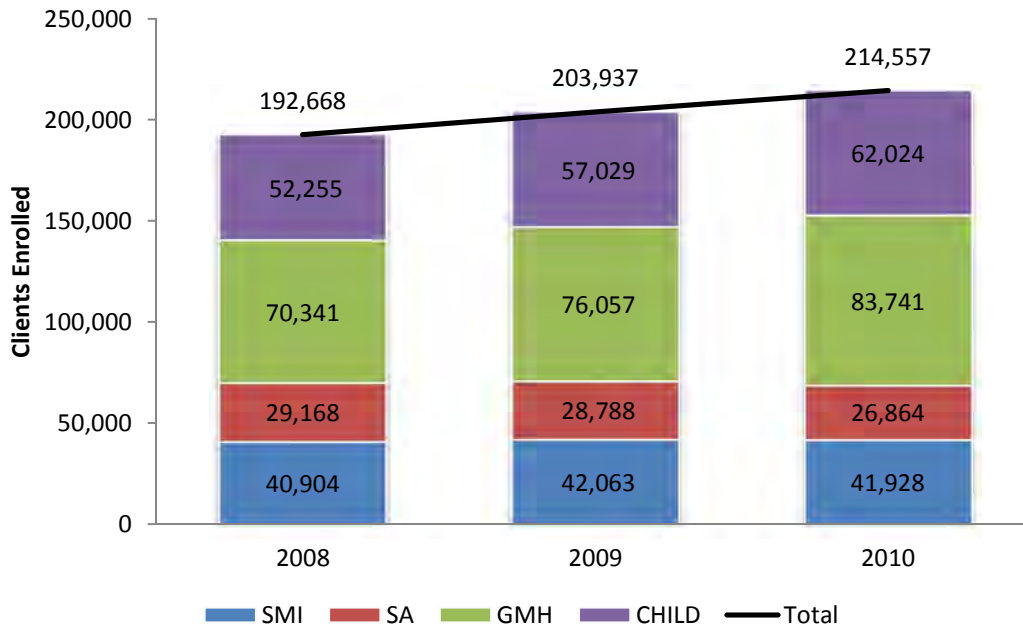
FY 2010 Enrollment			
Counties	**T/RBHA**	**Number Enrolled**	**Percent of Clients Enrolled Statewide**
Apache Coconino Mohave Navajo Yavapai	**Northern Arizona Regional Behavioral Health Authority (NARBHA)**	25,382	11.8%
La Paz Yuma Cochise Gila Graham Greenlee Santa Cruz Pinal	**Cenpatico Behavioral Health System (CBHS)**	28,574	13.3%
Pima	**Community Partnership of Southern Arizona (CPSA)**	42,686	19.9%
Maricopa	**Magellan of Arizona**	113,054	52.7%
Tribal Authority	**Navajo Nation**	1,977	0.9%
Tribal Authority	**Gila River Indian Community**	1,451	0.7%
Tribal Authority	**Pascua Yaqui**	1,042	0.5%
Tribal Authority	**White Mountain Apache**	390	0.2%

FY 2010 Demographics (Statewide Aggregate; n=214,557)

Client Financial Eligibility		Age Distribution		Race and Ethnicity	
Medicaid Title XIX:	81.8%	Birth –5:	4.1%	African American:	6.6%
Medicaid Title XXI:	1.7%	6-12:	13.2%	American Indian:	5.1%
Non-Title XIX/XXI:	16.4%	13-17:	11.1%	Asian:	0.6%
		18-21:	6.9%	Native Hawaiian:	0.3%
Gender		22-30:	16.3%	White:	77.1%
Male:	49.9%	31-40:	15.9%	Multiracial:	1.5%
Female:	50.1%	41-50:	16.1%	Refused to Answer:	8.9%
		51+:	16.4%		
		Median Age:	30.1 Years	Hispanic/Latino:	26.3%

When compared to information from the United States Census, ADHS/DBHS is able to determine whether or not its outreach programs are effective and if the treatment population adequately reflects the characteristics of the general population in Arizona. With respect to Gender, Race, and Ethnicity, those individuals in treatment are largely representative of Arizona's population, with select instances of specific groups being over-represented. For example, whereas African Americans and American Indians account for 3.6% and 4.5%, of the general population, respectively, these groups make up 6.5% and 5.1% of the treatment population.[10] However, while 29.8% of Arizonans indicate being Hispanic/Latino, this group accounts for 26.3% of those enrolled in the treatment population.

Furthermore, by using the prevalency data from the NSDUH, in comparison to enrollment rosters, ADHS/DBHS is able to establish expected substance abuse treatment penetration rates by gender and age band, and determine if any age groups may be underserved. For example, according to the most recent NSDUH information available, 3.6% of the treatment population should be females between the ages of 10-14, with 3.2% of the treatment population comprised of males ages 10-14; however, actual enrollment rates for these groups fell below the expected volume (females 0.37%; males 0.68%). The same was true for adults over the age of 55, regardless of gender, as this group was underrepresented in the treatment population (please see following figures). This level of micro-analysis is directly responsible for justifying two state priorities (see Application Table 3) for increasing enrollment for older adults, and children/adolescents, in need of substance abuse treatment.
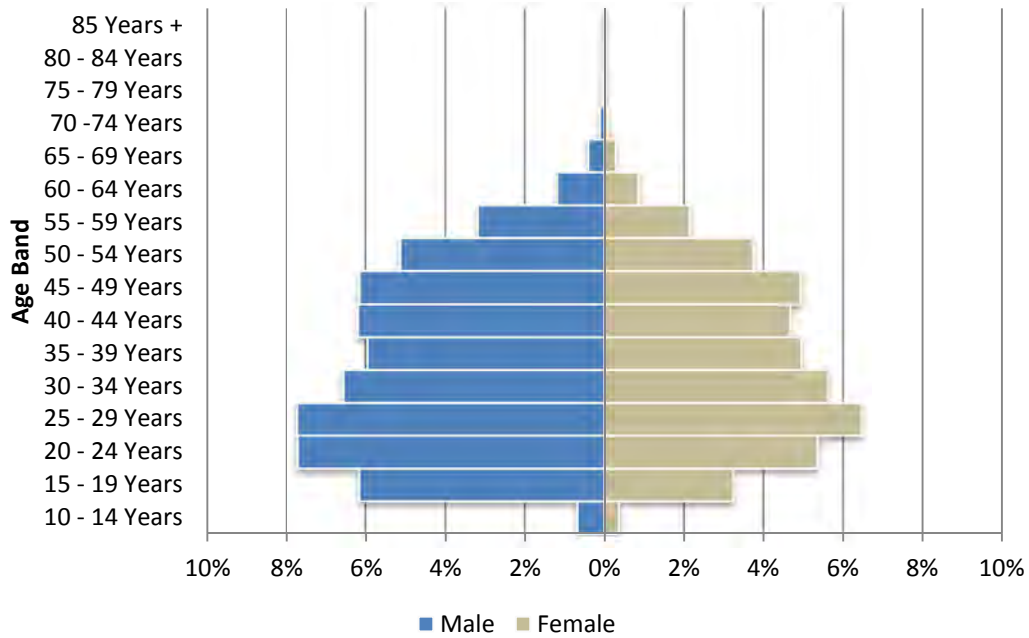
It is also important to note that this same analysis showed evidence that past State initiatives around increasing enrollment for women who may be pregnant or have dependent children, a SAPT priority population, have been successful – as the rates of women of child-rearing age (20-34 years) in treatment is greater than expected. Despite this performance, ADHS/DBHS will continue to focus on outreach and engagement efforts for this priority group and ensure gender-specific services are available and readily accessible.

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[10] U.S. Census Bureau, 2005-2009 American Community Survey

Distribution of Substance Abuse Treatment Need
by Age and Gender (FY10)

Age Band

85 Years +
80 - 84 Years
75 - 79 Years
70 -74 Years
65 - 69 Years
60 - 64 Years
55 - 59 Years
50 - 54 Years
45 - 49 Years
40 - 44 Years
35 - 39 Years
30 - 34 Years
25 - 29 Years
20 - 24 Years
15 - 19 Years
10 - 14 Years

10% 8% 6% 4% 2% 0% 2% 4% 6% 8% 10%

■ Male ■ Female
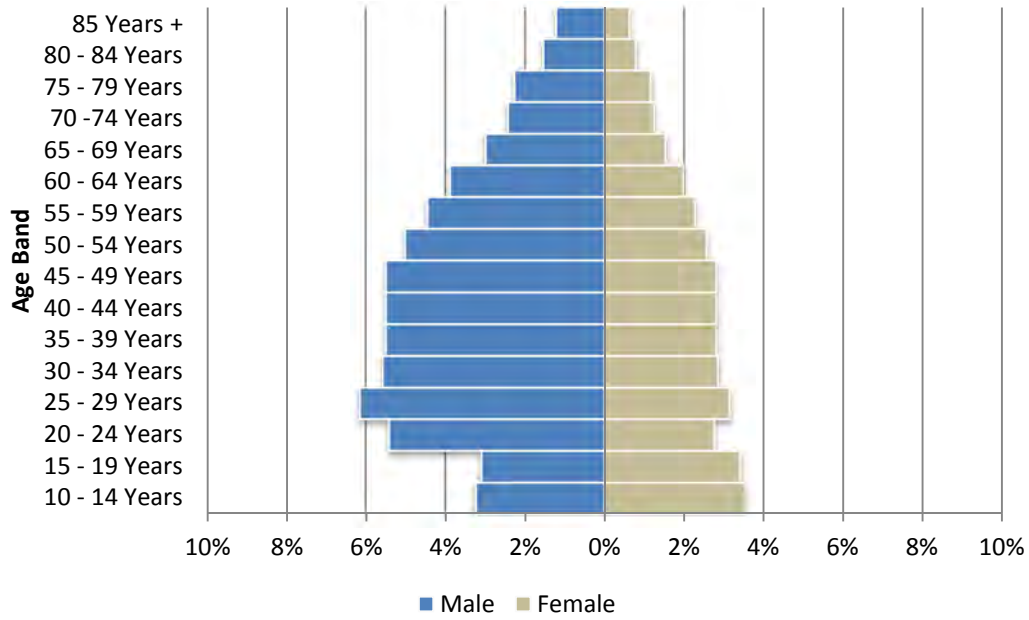
Distribution of Substance Abuse Treatment Provision
by Age and Gender (FY10)

Age Band

85 Years +
80 - 84 Years
75 - 79 Years
70 -74 Years
65 - 69 Years
60 - 64 Years
55 - 59 Years
50 - 54 Years
45 - 49 Years
40 - 44 Years
35 - 39 Years
30 - 34 Years
25 - 29 Years
20 - 24 Years
15 - 19 Years
10 - 14 Years

10% 8% 6% 4% 2% 0% 2% 4% 6% 8% 10%

■ Male ■ Female

The State's Strengths, Needs, and Priority Initiatives for Addressing Grant-Indentified Populations and Other Targeted Services

Despite the service limitations noted in the preceding section, and reflective of the State's economic situation, the Arizona Department of Health Services, Division of Behavioral Health Services works diligently with the Regional Behavioral Health Authorities, and Tribal Regional Behavioral Health Authorities to ensure the service delivery network presents individuals with a choice of multiple, highly-qualified providers, each offering varying levels of care spanning multiple treatment modalities. This section describes unique strengths, needs, and priority initiatives around specific groups or services.

- *Community-based services for adults with a Serious Mental Illness and Children with a Serious Emotional Disturbance*

Arizona's comprehensive recovery-oriented system of care for adults and children is fully integrated to address both the mental health, and substance use prevention and treatment, needs. The service delivery system is designed to operate, and provide services, in the least restrictive community-based environment available.

The prevention and treatment delivery network is in a period of significant transition with respect to adults with a serious mental illness. To begin, in April, 2011, the Arizona State Legislature passed ground breaking legislation creating, for the first time in the State's history, a State Housing Trust Fund, operated by the Arizona Department of Health Services, specifically for adults with serious mental illness. The Governor signed the bill into law and it became effective July 1, 2011. This new law requires ADHS to develop a permanent housing program and submit their first report to the legislature and Governor by September 2011. Over $2 million annually will be appropriated to the ADHS State Housing Trust Fund until Fiscal Year 2044. These monies will be used to purchase homes and apartment complexes through contracts with local Arizona non-profit organizations to increase the capacity of permanent housing for RBHA enrolled members who are Medicaid-eligible. All properties purchased with these funds will be deed restricted for the sole use of housing adults with serious mental illnesses for a twenty five year period. This program is being specifically designed to integrate individuals in recovery with their community.

Additionally, in an attempt to better understand the true needs of those served by the behavioral health system, the *Raise Your Voice Project* was created utilizing the Community Based Participatory Research (CBPR) – a recognized evidenced-based practice. Peers and family members were trained and facilitated 26 statewide focus groups where 370 peer and family participants decided what recovery meant to them; what services were most important; when, where and how they wanted services to be delivered; and how they expected behavioral health staff to respond to their needs. This qualitative data was then entered, verbatim, by peers and family members and then categorized and trended with SPSS Text Analysis software. Analysis of the data revealed eight consistent themes for our behavioral health system: individualized care, supportive services, peer support services, community-based resources, living arrangements, transportation, crisis services and integrated health services. The Workgroup compiled a written and statistical report on the findings of this project which has been made available statewide in July 2011.[11] ADHS/DBHS will use the information and recommendations from the *Raise Your Voice Project* to make improvements, wherever possible.

The Arizona Stigma Reduction Committee conducts statewide Arizona Dialogues (patterned after SAMHSAs participatory dialogues). The Arizona Dialogues are conducted by trained Co-Facilitators and

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[11] The full report can be viewed on the Division's website at http://www.azdhs.gov/bhs/transform.htm.

have been very successful in engaging groups in deep discussion and exploration of a variety of aspects of community inclusion and stigma. The goal of Arizona Dialogues is to raise awareness and affect positive changes in attitude and behavior toward persons with mental illness/substance use disorders and their families. Additionally, the Committee has developed presentations, which include experience sharing, to raise awareness of the negative effects of stigma and positive benefits of inclusion. The Committee conducts these programs all over the state and also has a presence at many health/wellness fairs and is an exhibitor at local conferences. In fiscal year 2011, the Committee developed and implemented a plan to establish six Regional Stigma Reduction Committees; this activity will continue into FY12, with the first already having been established in Pima County.

Because the Arizona Dialogues have been so successful, the Trauma-Informed Care Taskforce embarked on promoting the Trauma Informed Care (TIC) philosophy to the public behavioral health system through a Dialogue/Focus Group combination. The goal of this project is to develop a statewide TIC needs assessment, and to spread awareness concerning trauma informed care, particularly around sanctuary trauma. TIC Dialogues offer an avenue in which peer and family members become active participants in systems transformation by sharing their experiences and speaking about their needs and those of the community related to trauma.   Twenty-three TIC Dialogues are being conducted throughout the State, with the findings to be submitted to ADHS/DBHS for a needs assessment analysis in September, 2011. The TIC Taskforce will plan future activities based on the results of the needs assessment report.

The system of care for children and families in Arizona's behavioral health system has a great number of strengths. The Arizona Vision and Principles, the array of Covered Services, the strong partnerships with Family Run Organizations and commitment to the Child and Family Team Practice Model all provide a solid framework for continued system development. During the past three years the state has worked to improve care for the most complex needs children in the system and to reduce the use of out of home treatment through a number of initiatives.

The High Needs Case Management Initiative has brought almost 500 case managers with low caseloads at the provider level across the state. These positions have been developed over the past three years to help meet the needs of children with complex needs. Goals for the coming years are focused on refining the roles of these positions and to work to maintain these resources during a time of unprecedented financial stress on the state.

Additionally, the development of Generalist Direct Support providers over the past three years through the Meet Me Where I Am Campaign has spawned the development of programs providing direct support staff, available to work with children in their homes, at school, and in the community. Generalist Direct Support programs provide around the clock availability of staff for a sufficient number of hours /days per week to maintain youth in their homes and communities who would have otherwise required residential treatment. These are powerful tools available to Child and Family Teams (CFT) as a means to avoid the need for out of home placement or to reduce lengths of stay and return children to their home and communities more quickly and successfully. Goals for the coming year again focus on using these resources to fidelity in order to maximize their effectiveness and improve outcomes.

The Child and Adolescent Service Intensity Instrument (CASII) was introduced across the system as one way to help identify children and families with complex needs. During the coming year there is a plan to establish a standardized measure to help identify complex needs children ages birth to 5. Additional

goals include promoting the use of the CASII to increased fidelity and to examine ways to use the tool as a measure of functional improvement.

During the past 2 years the state has measured the fidelity of Child and Family Team Practice Model for complex needs children and families using the System of Care Practice Review, developed by the University of South Florida. 210 reviews per year have been accomplished using the tool over the past 2 years and results shared with 50 providers across the state covering domains of CFT Practice including: 1) Child Centered / Family Focused, 2) Community-Based, 3) Culturally Competent and 4) Impact. Both quantitative and qualitative data are presented to the providers and findings are used to develop practice improvement activities. Goals over the next year will be to continue to use the SOCPR and develop ways for providers to use the tool in coaching and supervision processes with Child and Family Team Facilitators.

Additionally, work will continue with system partners in Education, Juvenile Justice, and Child Welfare to promote the Child and Family Team Practice Model. Efforts will center on continued training as well as developing means to monitor out of home treatment and collaborate with system partners to look at ways to keep children in the community whenever possible. Data sharing agreements will also need to be pursued and accomplished.

- *Persons who use drugs by Injection*

In State Fiscal Year 2010 the public behavioral health system served 5,125 individuals who indicated using drugs by injection.[12] The following table details the demographic makeup of this group in comparison to the overall Substance Abuse population served during that same time period.

Intravenous Drug Users (Enrolled FY 2010)		All Clients with a Substance Use Disorder
Total in Population	5,125	**70,179**
Median Age (Years)	39.6	**35.0**
Gender Male	63.0%	**57.2%**
Female	37.0%	**42.8%**
Race White	91.0%	**81.9%**
Black	2.5%	**6.9%**
Native American	3.9%	**9.1%**
Asian	0.2%	**0.3%**
Hawaiian	1.5%	**0.5%**
Multiracial	0.9%	**1.4%**
Ethnicity Hispanic	26.2%	**25.5%**
Not-Hispanic	73.8%	**74.5%**
Percent Attending School	4.1%	**14.1%**
Percent with HS Diploma / GED or Greater	61.4%	**56.4%**
Employment Status Employed Full-Time	6.9%	**10.4%**
Employed Part-Time	7.1%	**7.3%**
Not Employed	86.0%	**82.3%**
Percent with a Recent Arrest	16.4%	**15.5%**
Housing Status Homeless	9.7%	**5.4%**
Not Homeless	90.3%	**94.6%**
Primary Substance Type Heroin	68.3%	**6.9%**
Methamphetamine	15.9%	**8.7%**
Alcohol	6.4%	**28.9%**
Crack/Cocaine	3.1%	**4.1%**
Marijuana	2.8%	**18.1%**
Other Opiates	2.7%	**2.7%**
Other Substances	0.7%	**4.4%**

As noted in the above table, more than 70% of injection drug users cite Heroin or other opiates as their primary substance of choice, in comparison, only 9.6% of non-injection drug users indicated opiates were their primary substance. ADHS/DBHS and the RBHAs have established a statewide network of 31 unique clinics offering methadone maintenance administration and treatment services to those with an opiate addiction – including those using drugs by injection. The geographical distribution of these clinics was detailed on the network inventory table included in the previous section of this application.

ADHS/DBHS ensures adequate capacity management for the IVDU population through two primary mechanisms. First, providers are required by contract to notify their RBHA when they have reached the 90% capacity threshold, as required by 42 U.S.C. 300x-23(a)(1). The system allows for these programs to request and receive additional funding when the population being served approaches a predetermined number indentified in their contracts. As the majority of IVDU treatment is done in an outpatient setting (both standard and intensive care), this additional funding allows the provider to expand services as necessary to accommodate more clients. Second, in April 2011, ADHS/DBHS revised its waitlist system to

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[12] Includes those who indicate 'injection' as the route of use for their primary, secondary, or tertiary substance type preferences; fiscal year 2011 enrollment information will be made available in October, 2011.

be web-based and in real-time. Prior to this development, there was a significant delay between the time a priority population member (IVDU) was placed on a waitlist and DBHS being notified.[13] The new system sends an alert to the RBHA and the Division immediately upon an individual seeking residential treatment being waitlisted for not being able to meet the placement timeframes established in 42 U.S.C. 300x-23(a)(2)(A)(B).

Despite these strengths, ADHS/DBHS has identified two areas of need for the injection drug using population. To begin, ADHS/DBHS is placing a concerted emphasis on the need to expand network capacity as it relates to the number of certified physicians who are licensed to provide non-methadone Medically Assisted Therapy (MAT) services to those with an opiate addiction – specifically for Buprenorphine and Suboxone. As of April, 2011, the system had 41 such physicians prescribing these medications, with the majority operating out of the State's urban centers of Phoenix and Tucson. The lack of access to these physicians in the rural areas of the state restricts consumers with an opiate addiction to only methadone maintenance, and adds to the increased utilization of transportation services. The rural RBHAs (NARBHA and Cenpatico) are working to add Buprenorphine prescribers to their network in the most cost-effective way possible.

Furthermore, in early fiscal year 2012, ADHS/DBHS instituted a statewide pilot program in an effort to expand the use of non-Methadone Medically Assisted Therapies to those with an opiate addiction. Specifically, RBHAs were permitted to expend a portion of their annual SAPT general services allocation to provide Buprenorphine or Suboxone to non-Medicaid eligible behavioral health recipients.[14] Prior to this pilot, SAPT funding for opiate medications had been limited to Methadone due to the high costs of the alternatives. This pilot is slated to run through fiscal year 2012 and DBHS will review the individual program' outcomes and, if positive, revise policy as appropriate to further expand non-methadone provision for SAPT-eligible consumers. [15]

- *Adolescents with substance abuse and/or mental health problems*
At any given time there are over 47,000 children and adolescents enrolled in Arizona's public behavioral health system. For the past 12 years, the development of the state-wide Children's System of Care (CSOC) has been guided by the Arizona Vision and Principles which were developed to model SAMHSA's System of Care to serve children with Severe Emotional Disturbance. As a state-wide model, there are a number of unique advantages for system of care development. The states Covered Behavioral Health Services Guide provides a wide array of services including respite, support and rehabilitation, and other community based services vital to supporting the goal of keeping children with their families and close to their school and community whenever possible. There is a strong collaboration with Family Run Organizations across the state to engage families, provide support, guidance, and self advocacy. There is significant family and youth participation as meaningful members on policy making committees at the state and local level and there are family members employed at the provider level in roles such as Family Support Partners (FSP).

An area of need, and one of the states' priority initiatives identified for the next five years, is to build upon family member and youth involvement in the system of care. Goals for FY 2012 include adoption of National Federation of Families Core Competencies for family members working in the system. Currently, the role of the FSP is not clearly defined in the Children's System of Care, and as a result the

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[13] The Division's waitlist management system is used to capture information for non-Medicaid clients only

[14] "General Services Allocation" refers to monies not already set aside for the SAPT-designated priority populations

[15] For more information on this pilot program please see Table 3, Priority 10, of this application.

manner in which they are trained, supervised and incorporated into the Child and Family Team process is inconsistent. Similarly, the collaboration between the state's two primary Family Run Organizations, (The Family Involvement Center and MIKID), and the local provider organizations also lack consistency, resulting in a diminished potential benefit for children and families. As a state, Arizona has experienced the benefits of working together with family members, youth, and Family Run Organizations as a means to identify priorities, define policy, and to engage youth and families in their own process of recovery. The state's Children System of Care Plan outlines steps toward developing increased consistency for family and youth roles and to continue to strengthen family and youth voice and involvement in system development. Current goals are focused toward defining youth and family member roles in serving as members of Child and Family Teams. It will be essential to define consistent roles with job descriptions as well as training and coaching structures. Specific targets for the number of employed family members within the system will also need to be developed. Collaborative arrangements with the Family Run Organizations to recruit and support youth and family members in their roles as providers of service and participants on state and local boards and committees will also need to be more clearly defined.

Another area of focus for the state has been to promote the development of Evidence-based Practice (EBP) in the areas of screening, and providing services, for substance use disorders among adolescents. Each of the state's Regional Behavioral Health Authorities (RBHAs) are charged with ensuring there are sufficient providers of substance abuse treatment within their geographic service areas, including Outpatient, Intensive Outpatient, and Inpatient / Residential Treatment services, available to meet the needs of their enrolled population. This is measured with an annual Network Inventory which identifies the number of providers as well as the EBP model that is employed. EBP's include those such as The Matrix Model, ACRA, Seven Challenges, Motivational Interviewing, CBT and CYT. Each of the RBHAs conducts annual monitoring activities for Intensive Outpatient and Residential programs through medical record audits and interviews with key staff.

Arizona is currently focused on pulling together efforts from the treatment sector with those from the prevention arena, as evidenced by the FY 2012 Annual Work Plan. Statistics show that marijuana use specifically is on the rise in Arizona among adolescents. As a state, Arizona is attempting to find creative ways to engage and encourage adolescents to avoid substance use through prevention efforts while at the same time in, the treatment arena plans are focused on the need to more effectively screen for substance use disorders for those adolescents entering the behavioral health system. There is concern that substance use disorders among adolescents in the behavioral health system are under-identified and that more effective screening procedures could help identify and engage more youth in need of treatment into services. As a result the FY 2012 Work Plan identifies the goal of establishing a standardized screening process for all providers by the end of the fiscal year. [16]

- *Children and youth who are at risk for mental, emotional and behavioral disorders, including, but not limited to addiction, conduct disorder and depression*

The Children's System of Care incorporates multiple strategies to identify and direct prevention activities towards children and youth in need, and utilizes the resources of numerous system partners to accomplish this.

Arizona's *First Things First* program has led to an increased capacity to provide preventive health services for children ages 0 – 5 through funding from the Early Education and Health Development

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[16] For more information on this initiative, please see Table 3, Priority 1, of this application.

Board. Additionally, the Arizona Department of Education (ADE) administers the Federal *Safe and Supportive Schools* grant; the Division is a collaborating partner in this project. In 2011, the Division, in concert with the Department of Education, and other system partners focusing on children and youths, developed a training guide specifically designed to assist behavioral health providers better interact with the educational system.

Despite these accomplishments, there are still areas of increased need and attention; specifically, Family Run Organizations report a need for increased natural and peer supports for families. There is also a need for increased opportunities for youth leadership strategies for youths in recovery from behavioral health disorders. Furthermore, the system must work to increase the familiarity, understanding, and knowledge of early identification of warning signs indicative of suicidal risk among gatekeepers, i.e. educators, medical providers, and other adults who have access to youths.

Accordingly, ADHS/DBHS and its partner agencies have identified several priority initiatives to address these needs. The full list of initiatives and objectives are detailed in Children' System of Care Plan, including Increasing the use of evidence based best practices and trauma informed care; Increasing the availability and use of Peer and family supports, and improving collaborative efforts with other child serving agencies.[17]

- ***Pregnant women and parents, with dependent children, that have a substance use and/or mental health disorder***

In fiscal year 2010 there were 70,179 individuals enrolled in Arizona's public behavioral health system for substance abuse treatment. Whereas, the overall behavioral health population is divided nearly evenly between males and females; the substance abuse population is comprised of more men than women – 57.2 percent versus 42.8 percent respectively. During this same time period, there were 9,777 substance abusing females enrolled in treatment who met the criteria for priority placement, as they were either pregnant and/or had dependent children. The following table details the demographic makeup of this group in comparison to the overall Substance Abuse population served during that same time period. As indicated in the table, one out of four of these individuals (24.5%) cited alcohol as their primary substance, with methamphetamine and marijuana being the next most commonly abused substances.

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[17] The Children's System of Care Plan has been added as an attachment to this application.

Pregnant Females and Females with Dependent Children (Enrolled FY 2010 – with a Substance Use Disorder)			All Clients with a Substance Use Disorder
Total in Population		9,777	**70,179**
Referral Source	Self Referred	42.2%	**45.9%**
	Criminal Justice	13.4%	**18.1%**
	Economic Security	10.1%	**3.1%**
	Other Source	14.7%	**13.1%**
Median Age (Years)		31.7	**35.0**
Race	White	80.7%	**81.9%**
	Black	6.7%	**6.9%**
	Native American	10.2%	**9.1%**
	Asian	0.3%	**0.3%**
	Hawaiian	0.5%	**0.5%**
	Multiracial	1.7%	**1.4%**
Ethnicity	Hispanic	26.5%	**25.5%**
	Not-Hispanic	73.5%	**74.5%**
Percent Attending School		9.5%	**14.1%**
Percent with HS Diploma / GED or Greater		60.0%	**56.4%**
Employment Status	Employed Full-Time	11.9%	**10.4%**
	Employed Part-Time	9.3%	**7.3%**
	Not Employed	78.8%	**82.3%**
Percent with a Recent Arrest		12.2%	**15.5%**
Housing Status	Homeless	3.0%	**5.4%**
	Not Homeless	97.0%	**94.6%**
Primary Substance	Alcohol	24.5%	**28.9%**
	Methamphetamine	14.1%	**8.7%**
	Crack/Cocaine	4.6%	**4.1%**
	Marijuana	13.6%	**18.1%**
	Heroin	4.2%	**6.9%**

The service delivery network has a rich array of providers available to treat these individuals, including more than twenty residential programs offering evidenced based, gender specific, programming to pregnant women, and women with dependent children, in accordance with nationally-recognized standards. For example:

- **The Haven** is a level II residential treatment program that serves both pregnant/post partum women and women with dependent children. Program places emphasis on the multi-dimensional holistic approach to substance-use disorders. Services include peer support, on-site child care and "Native Way". Native Way services include use of Medicine Wheel, Smudging, Talking Circles, Sweat Lodge, Pipe ceremonies, Native music as art, and Storytelling.

- **Weldon House**, a facility operated by the National Council on Alcoholism and Drug Dependence (NCADD), is a unique supported independent living environment that offers specialized, gender-specific living to women and their children. Weldon House is innovative in that the women with their child/children have their own fully furnished apartment that provides them with the setting in which to learn hands on how to manage a home, parent their child/children and develop a family.

- **Community Bridges/Center for Hope** is a level II residential facility that is a nationally recognized best practice program targeting pregnant/ post-partum women and women with

dependent children. Services include on-site child care, relapse prevention, recovery support groups, GED preparation, employment training, and grief and loss counseling.

Another significant strength of Arizona's system, especially as it relates to capacity management for this priority population has been the recent (April, 2011) implementation of a new waitlist tracking system. Prior to this development, there was a significant delay between the time a priority population member (pregnant or parenting female, and Injection Drug User) was placed on a waitlist and ADHS/DBHS being notified. The new system is web-based, and sends an alert to the RBHA and ADHS/DBHS immediately upon an individual seeking residential treatment being waitlisted when a provider is unable to meet the placement timeframes established in 42 U.S.C. 300x-23(a)(2)(A)(B).

Despite the comprehensive service package available to substance abusing women who are pregnant or have dependent children, there are still areas of need in Arizona; specifically, the State aims to improve the quality and quantity of gender-responsive practices available in our standard and intensive outpatient programs. Furthermore, ADHS/DBHS has been working to address the lack of available childcare options for these individuals; in many cases, child care has been noted as the primary barrier preventing females from entering, or continuing, a treatment program. In early calendar year 2011, the RBHA's were permitted to utilize a portion of their SAPT funds to increase the availability of childcare. Thus far, the response to this allocation has been positive.

Additionally, ADHS/DBHS is required by both the terms of the Block Grant, and by Arizona Revised Statute (A.R.S.) §36-141(B) to give treatment priority to pregnant females who abuse drugs or alcohol; in this respect, the Division has set a goal of increasing enrollment & penetration rates by 5% annually for pregnant females and females with dependent children, with a substance use disorder or dependence.

- ***Military personnel (active, guard, reserve, and veteran) and their families***
Addressing the mental health and substance dependence needs of service members and veterans is quickly becoming a major priority for the Division of Behavioral Health Services and its partner agencies. To begin, Arizona's Coalition for Military Families supports the health and well being of military families, and the Arizona Suicide Prevention Coalition has a subcommittee devoted to the prevention of suicide among those who have served in the military.

According to a recent survey, veterans of the Iraq and Afghanistan wars are twice as likely as other Arizonans, and veterans of other wars, to binge drink. These veterans also engaged in use of illicit substances (specifically marijuana and prescription drug abuse) at greater rates than other veterans and other Arizonans (St. Luke Health Initiative Survey, 2010). That being the case, it is imperative that the public behavioral health system be able to engage these individuals into treatment and assist them in recognizing and addressing their addiction.

ADHS/DBHS has specific initiatives to address the need for behavioral health services for veterans, National Guard members, the Reserve, and families of military members, including designing an e-learning tool for the assessment of traumatic brain injuries (TBI). The Arizona Department of Veterans' Services, the Governor's Council on Spinal Cord and Brain Injury, the Arizona Brain Injury Association, and St. Joseph's Hospital/Barrow's Neurological Institute support this initiative. ADHS/DBHS has also sponsored, provided, or arranged trainings for mental health professionals, or other providers, on Traumatic Brain Injury for returning veterans or their family members.

One of Arizona's priorities is to increase the expertise, competency, ability, and comfort of BH providers

to provide quality behavioral health services for service members, veterans, and their families – ultimately resulting in an increased number of service members, and veterans, enrolled and receiving services through the public behavioral health system.[18]

To achieve this objective in the upcoming years, ADHS/DBHS will collaborate with the Arizona Coalition for Military Families, the VA, and stakeholders to develop advanced training in cultural competency with military families for BH providers, as well as provide access to the At-Risk training for families of veterans. Furthermore, ADHS/DBHS is working to provide training for service members, veterans, and their families in recognizing signs of PTSD and TBI and the referral process.

Additionally, in order to determine the success of the above initiatives, and allow for an accurate means of calculating enrollment, ADHS/DBHS will add a demographic data field to the Client Information System (CIS) to capture the veteran status of all adult behavioral health recipients. This field will become required in January, 2012.

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[18] Please see Table 3, Priority 3, of this application for more details.

- ***American Indians/Alaska Natives, persons with disabilities, racial and ethnic minorities, the LGBTQ community, and other historically underserved populations***

Culture, language, and society each play a pivotal role in the design and delivery of behavioral health services and understanding these roles enables the behavioral health system to act in a responsive manner to the needs of racial and ethnic minorities, as well as other underserved populations. Today's America is unmistakably multicultural, and since there are a variety of ways to define a cultural group (e.g., by ethnicity, religion, geographic region, age group, sexual orientation, or profession), many people consider themselves as having multiple cultural identities. Culture affects how individuals communicate symptoms or seek help, what coping skills they have and how much stigma they attach to mental illness. Culture also affects strengths, such as resilience and adaptive ways of coping that people bring into the treatment setting. Likewise, the cultures of the clinician and the service system influence diagnosis, treatment, and service delivery (U.S. Department of Health and Human Services, 2001).[19]

To this extent, ADHS/DBHS has developed a comprehensive service structure designed to address the needs of Arizona's richly multicultural population, including racial and ethnic minorities, American Indians and Alaskan Natives, persons with disabilities, and the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) population. Specifically, ADHS/DBHS has created a Cultural Competency Plan that is data driven and outcome based. The plan is a comprehensive document that includes the Center for Medicaid Services (CMS) Requirements, Arizona Health Care Cost Containment System (AHCCCS) Contract Requirements, AHCCCS Policy Requirements, AHCCCS Corrective Action Plan Requirements, Grant Requirements, and Culturally and Linguistically Appropriate Services (CLAS) and Limited English Proficiency (LEP) standards that provide strategies and initiatives for all underrepresented/underserved populations. The T/RBHAs are contractually required to create and implement a cultural competency plan in their region that ensure culturally and linguistically appropriate services as outlined in the DBHS Cultural Competency Plan. As a result the initiatives and requirements impact all providers in all areas of service access and delivery in Arizona.

Additionally, multiple committees have been created and tasked with providing advice and operational guidance directed towards integrating culturally sensitive care and recognition into the service delivery system; this includes:

- *The Cultural Competency Steering Committee* – this governing body of cultural competency is comprised of active participants from all functional areas of the division to ensure that cultural competency penetrates all levels of DBHS. The purpose of the committee is to strategize the implementation of the cultural initiatives and provide input in the revision of cultural competency policies and contract amendments with analysis of culturally and linguistically appropriate services.

- *The Cultural Competency Operations Committee* – comprised of Cultural Competency leaders and Tribal Liaison representation from all T/RBHAs areas, the purpose of the committee is to ensure implementation, monitoring and compliance of cultural competency plans and initiatives. This body also provides a forum for discussion of culturally relevant services and policies based on identified need and geographic service area.

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[19] U.S. Department of Health and Human Services, 2001. *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. http://www.surgeongeneral.gov/library/mentalhealth/cre/execsummary-1.html

- *The Mental Health Roundtable for the Deaf and Hard of Hearing* - provides a forum for dialogue, decision making, and discussions regarding the continuum of comprehensive and integrated statewide behavioral health services that meet the needs of the Deaf and Hard of Hearing youth and adults. In addition, it conducts research about educational programs for agencies to improve treatment options and identify the means to promote education to mental health professionals on the appropriate and culturally relevant individualized client services for the Deaf and/or Hard of Hearing population.

- *The LGBTQ Advisory Committee* – meeting on a monthly basis, the committee develops an annual work plan which informs and guides all of ADHS/DBHS' activities related to prevention and treatment of substance use disorders and suicide in LGBTQ populations.

- *The Native American Behavioral Health Forum* – occurring bi-annually, provides an opportunity for the various Tribal Authorities to convene with ADHS' staff and discuss current and upcoming behavioral health issues on the respective reservations, including new developments in service delivery and treatment practices.

ADHS/DBHS has also taken additional steps to further emphasize cooperation and coordination with the state's numerous tribes. This includes maintaining a Tribal Contract Administrator within ADHS/DBHS; this employee, who is also a member of the Navajo Nation, oversees and manages the State's five Intergovernmental Agreements (IGA) designed to provide behavioral health services to members of the respective tribes. American Indians and Alaskan Natives in Arizona receive behavioral health services from Indian Health facilities, 638 Tribal behavioral health programs, and the State's managed care behavioral health providers which are administered by the Division of Behavioral Health Services.

Additionally, each RBHA is required by contract to employ a dedicated Tribal Liaison responsible for working with the tribes to increase access to the state behavioral health system and its services, administered by the RBHAs, and to coordinate care with tribal, Indian Health Services, and RBHA providers on the uniquely remote and rural tribal reservations.

As is to be expected, undertaking an ambitious exercise such as implementing a system-wide cultural competency plan, in a complex service delivery structure such as that of Arizona's, requires an acute oversight and monitoring process. ADHS/DBHS reviews multiple data feeds on a recurring basis, conducts extensive demographic and service utilization reviews, and publishes various reports detailing system performance. These reports, available to the general public, are accessible at http://www.azdhs.gov/bhs/reports.htm, and include:

- *The Annual Diversity Report* - a comprehensive analysis of the racial and ethnic populations served by the Division. Information is pulled from the Client Information System (CIS) with a focus in demographic, programmatic, and utilization of services. The information allows ADHS/DBHS and its contractors the ability to explore the diversity of the population receiving services, while providing the opportunity to initiate further discussions on the importance of race, ethnicity, culture, and social influences as vital elements in the provision of services and how to provide culturally and linguistically effective care for diverse cultural and racial groups.

- *The Annual Diversity Episode of Care/Penetration Report Analysis* - provides an annual analysis of T/RBHAs Quarterly Diversity Episode of Care/Penetration Reports. The annual report allows for an overview of status on diverse populations that are served. Information is provided in a

format that focuses on areas of policy, marketing, outreach, prevention, training, and data outcomes. The analysis report provides a forum where projects, initiatives, marketing, outreach, prevention, and training efforts and/or status updates can be highlighted.

- *The Semi-Annual Language Services Report* – captures the linguistic need, primary language, Deaf and Hard of Hearing, Sign Language services, interpretive services, translation services, traditional healing services, and comprehensive lists of translator language abilities. The report is produced on a semi-annual basis by the T/RBHAs, which provides information that is tracked and trended throughout the year to assist with planning of activities based on need.

- *The Annual Effectiveness Review of the Cultural Competency Plan Report* - provides insight to the strengths, gaps and needs within cultural competency services. The primary focus is to address areas identified as a gap and/or need of the previous year's plan and assist in developing the upcoming cultural competency plan. The report assists in the monitoring of the T/RBHAs to ensure that goals are attainable and accomplished with an understanding of their geographical service area. A focus on data and measurable outcomes is imperative in understanding what drives a system and providing cultural relevant services to persons accessing the behavioral healthcare system.

Through methods of data collection and community collaboration, ADHS/DBHS has determined that many disparities and/or gaps still exist with regard to the inclusion of tradition, cultural beliefs, diverse cultures, and race and ethnicity, as vital elements affecting the quality of care and the effectiveness of services provided. Therefore, ADHS/DBHS has determined continued efforts on data driven outcomes and new initiatives and programs to provide a comprehensive range of inclusive and high quality services for all the underserved/underrepresented populations identified within Arizona's geographic regions is essential in providing system change.

Specifically, there is a need to adequately gather information on cultural awareness within the system, and then establish a mechanism to provide/promote education, awareness, and trainings related to special populations and underrepresented/underserved populations. A workgroup has been formed to assess DBHS' cultural competency needs and provide educational forums quarterly on cultural competency topics. ADHS/DBHS is also working to develop a cultural competency retreat for executive staff specific to the needs of management in terms of cultural competent services and culturally sensitive environments.

With respect to American Indians and Alaska Natives, the Department of Health Services' Division of Public Health Statistics, has identified several health disparities, specifically differences in mortality rates, between this group and the general population. For example, American Indians and Alaska Natives are more than twice as likely to die from complications associated with Diabetes than others in Arizona; similarly, this group is nearly 3.5 times more likely to die from alcohol-related illnesses than the general population.

Accordingly, past reports have revealed a need for increased outreach and collaboration with the tribes. To address this, ADHS/DBHS will include collaboration efforts such as tribal consultations, relationship building strategies, trainings on cultural preferences in service provision, and meetings with tribal liaisons, to provide the foundation where initiatives can be developed to identify need within these communities.

ADHS/DBHS has set numerous priority initiatives around enhancing the service quality and appropriateness for racial and ethnic minorities, American Indians and Alaskan Natives, persons with disabilities, the LGBTQ population, and other historically underserved groups. These initiatives include, yet are not limited to:

- Developing and maintaining ongoing trainings for diverse populations in Cultural Competence, CLAS standards, LEP and special populations. Workgroups will be created to update cultural competency curriculums and trainings to include current national trends. In order to create awareness of special populations, cultural competency educational series will be focused on racial/ethnic minorities, refugees, HIV/AIDS, LGBTQ, military members, Deaf and Hard of Hearing, disabled persons, Blind and Visually Impaired, and Tribal Populations.

- Identifying needs and enhancing services for treatment and prevention related to the Lesbian Gay Bisexual Transgender Questioning (LGBTQ) populations. Participation in the LGBTQ Advisory committee allows collaborative efforts that resulted in trainings, educational forums and workgroups specific to LGBTQ populations. In addition, workgroups to identity the needs and create the mandatory trainings that will accompany the additional LGBTQ data elements of Gender Identity and Sexual Orientation. This activity is ongoing and increases the awareness of requirements in policy, contract amendments and monitoring to improve service delivery in this area. DBHS in collaboration with University of Arizona conduct comprehensive statewide assessments and climate surveys for organizational and staff level individuals to provide a baseline and trending of data, on LGBTQ populations. FY2011-2012 will focus on creating of protocol and reporting practices related to the new data elements of Gender Identity and Sexual Orientation which became mandatory data collection elements on July 1, 2011.

- Facilitating the increase and improvement of American Indian access to behavioral health services. RBHAs Tribal Liaisons will develop and promote American Indian initiatives, collaborate with tribes in intergovernmental agreement negotiations, and establish formal approvals to ensure the provision of behavioral health services on Indian reservations. The Division will respond to tribal requests for assistance in addressing issues related to behavioral health services; review Arizona Revised Statute (A.R.S.) §12-136 for incorporation into the DBHS Provider Manual; review AHCCCS Provider Requirements Non-IHS/638 behavioral health Service Providers on Tribal reservation lands, and; collaborate with other federal (VA & IHS), State, tribal, and private agencies to improve access to behavioral health services for American Indian Veterans. Additionally, the State will begin collaborations with Indian Health Services Area Offices to establish ongoing coordination of care meetings for American Indian Veterans needing behavioral health services.

- ***Individuals with tuberculosis and other communicable diseases***

In accordance with 42 U.S.C. §300x-24(a) and 45 C.F.R. §96.127, ADHS/DBHS ensures that Tuberculosis (TB) services are available and provided as needed to individuals receiving treatment for a substance abuse disorder or dependence (SUD).

The T/RBHAs are required by contract to refer all persons with a SUD for tuberculosis services, and ADHS funds all Counties within the state of Arizona, as well as several Tribal governments, for an array of TB screening and treatment services. Substance abuse treatment providers are aware of county services and utilize them through the referral process. Additionally, requirements to provide access to TB screening in residential environments are included in agency licensure standards and are monitored through the ADHS/Office of Behavioral Health Licensure (OBHL). These requirements are published in the current Administrative Rules for Behavioral Health Licensure.

Statewide oversight of tuberculosis is managed by The Arizona Department of Health Services (ADHS) Office of Infectious Disease Services (OIDS). OIDS is responsible for monitoring, controlling, and preventing infection, disease, and death associated with tuberculosis in Arizona through surveillance, data analyses, health education, guidelines, consultation, epidemiological investigations, and rules.

There were 232 reported cases of TB in Arizona in 2009, representing a 2% increase compared to that of 2008.[20] However, Arizona's TB infection rate of 3.5 cases per 100,000 persons was less than the U.S. rate of 3.8 cases per 100,000. Overall, in Arizona, 66% of the identified TB cases were among individuals born outside of the United States; 17% of cases occurred among people in correctional facilities; and 7% of cases involved people who also had HIV co-infection. Importantly, none of the 232 documented cases in Arizona were found within the substance using treatment population.

Arizona will continue to target specific populations for TB prevention activities including those with a substance use disorder, regardless of substance preference or route of use. ADHS/DBHS will utilize resources to plan, develop, and implement presentations for state-wide, accessible, free online trainings and educations on TB and the importance of testing for substance-using individuals.

- ***Persons with or at risk for HIV/AIDS and who are in need of mental health or substance abuse early intervention, treatment or prevention services***

Although last determined to be an HIV-Designated State by the Centers for Disease Control (CDC) in Federal Fiscal Year 2008, Arizona has continued to obligate funds and provide HIV prevention and early intervention services at a level commensurate with that of past Designated time periods as outlined in 42 U.S.C. §300x-24(b) and 45 C.F.R. §96.128.

The Office of HIV has nationally-recognized prevention and early intervention services targeting HIV-positive individuals statewide, including MSM (men who have sex with men), African Americans, and non-Hispanic women. The HIV/AIDS, Sexually Transmitted Disease, and Hepatitis C programs have been merged, which has positively impacted Arizona's HIV Prevention activities. This integration was based on evidence showing that the modes of transmission for HIV, Hepatitis and other Sexually Transmitted Diseases are virtually identical, and epidemiological data clearly demonstrates a link between HIV, Hepatitis, and STD transmission and co-morbid patterns.

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[20] 2010 Tuberculosis counts were not yet available at the time of application submission. These numbers will be updated at a later date.

HIV prevalence rates continue to rise in Arizona. Prevalence of reported HIV infection is 216.27 cases per 100,000 persons. Currently, there are 14,265 persons living with HIV/AIDS in Arizona, a rise of 30% in 5 years. The increase in prevalence rates appears to be due to the efficacy of multi-drug treatments for HIV infection, which have sharply reduced HIV-related death. Additionally, Arizona's increased population growth may be contributing to an increase in prevalence, as 22% of prevalent cases were first diagnosed in a state other than Arizona.

Arizona has established several priorities related to prevention and Early Intervention services for HIV, among them is developing a better method of assessing the need for HIV services in the rural and border areas of the State, and creating an online training program for providers explaining the requirements surrounding HIV Early Intervention Services.

- *Individuals with mental and/or substance use disorders who are homeless*
ADHS/DBHS works with its State partners and contractors to provide needed services to homeless individuals. To begin, on an annual basis, ADHS/DBHS staff, and other volunteers perform a point-in-time street and shelter count to determine the number of homeless individuals in Arizona, including those with a serious mental illness, or a co-occurring serious mental illness with a substance use disorder.[21]

2010 Estimated Totals

Sheltered Persons	Unsheltered Persons	Sheltered Persons with an SMI	Sheltered Persons with Chronic Substance Abuse	Sheltered Persons with SMI and Substance Abuse
7555	4290	2313	1478	823

Information obtained from this exercise, including that in the above table, is compiled into an annual report by the Arizona Department of Economic Security; the most recent report noted that there may be as many as 22,000 homeless people in Arizona on any given day, including persons who are in emergency shelters, transitional housing, or other locations such as on the streets, camped in forests, or living in cars or buildings that are unsafe and/or unsuitable for habitation. Additionally, a large percentage of persons in shelters and transitional housing experience problems with substance abuse, and discrimination against homeless persons is a substantial barrier to housing.[22]

Arizona has placed an increased emphasis on addressing and alleviating homelessness; specifically, in April, 2010, the Governor's Office established the *Arizona Interagency on Homeless and Housing Committee*, this group is charged with developing strategies to end homelessness in Arizona. The Director of the Department of Health Services serves on this Committee. Additionally, the Division has allocated funding across the system in a manner that allows homeless individuals with SMI and/or substance use disorders to be served through multiple mechanisms, including:
- Community Mental Health Block Grant (CMHS) – Funds provided by the mental health block grant are utilized for services to persons with serious mental illness and children with serious emotional disturbance, including those who are homeless or at imminent risk of being homeless.
- Substance Abuse Prevention & Treatment Block Grant (SAPT) – Provisions are made through the SAPT block grant for services to be delivered through street outreach/drop-in centers serving

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[21] "Shelter" refers to emergency shelters and homeless transitional housing.

[22] https://www.azdes.gov/InternetFiles/Reports/pdf/2010_homelessness_report.pdf

homeless individuals with substance use disorders at high risk for HIV, in addition to other community settings such as probation offices, domestic violence facilities and homeless shelters.

- State General Fund Revenue – State general funds allocated as a match for PATH federal funds are specifically targeted for persons who are homeless and have a serious mental illness and/or a co-occurring substance use disorder.

ADHS/DBHS receives a PATH grant to provide services to persons who are homeless, at risk of becoming homeless, and those determined to have a SMI, including those with a co-occurring substance abuse disorder. Providers conduct outreach in locations where homeless individuals gather such as food banks, parks, vacant buildings and the streets. The PATH grant provides community education; field assessment and evaluations; hotel vouchers in emergency situations; assistance in meeting basic needs (i.e. applications for Medicaid, SSI/SSDI, food stamps, coordination of health care, etc.) transition into a behavioral health case management system; assistance in getting prescriptions filled; moving assistance; and referrals for both transitional and permanent housing.

2010 PATH Outreach Efforts

Outreach	Referrals	Enrolled in PATH
9,382 persons	399	3,386

Categories of Persons Served					
Veterans	Persons with HIV	Persons with Hepatitis C	Persons released from the Justice System	Persons with an Axis I Diagnosis	Persons with an Axis I Diagnosis and a Substance Abuse disorder
134	10	21	506	2,136	867

Furthermore, provider recipients of PATH funds are required to form working relationships with the Veterans Administration Medical Center, the State Veterans' Services, and the U.S. Vets to assist with coordination of services for homeless veterans. This includes coordinating mental health care, benefits assistance, medical care, emergency, transitional, and permanent housing to homeless vets and participation in Stand Downs and Project Challenge events, including developing collaborations with local agencies and hospitals to increase the location and services to Veterans who meet the PATH eligibility criteria.

In response to the requirement from SAMHSA, and in an effort to gather meaningful data for program analysis and evaluation, all Arizona local PATH teams are utilizing the Homeless Management Information System (HMIS). All information received regarding HMIS from the federal and local levels (e.g.: trainings, presentations, websites, webinars, teleconferences and materials) is shared with PATH funded agencies' Executive Directors, Administrative/Program Directors, Outreach workers and Front Line staff through email transmissions and statewide teleconferences. In November 2010, Arizona conducted a training session, in conjunction with the PATH TA Center/Center for Social Innovation. The TA provided several sessions on data collection to strengthen HMIS strategies, educate outreach workers on supported housing programs, promote effective Veterans outreach, and develop employment opportunities for PATH enrolled adults.

Despite the progress made by ADHS/DBHS and its numerous partners, including PATH-funded providers, in helping those who are homeless, there are still many areas where more can be done. Specifically, there is a need for emergency, transitional, and permanent supportive housing based on a harm-

reduction model for dually diagnosed consumers who are not maintaining abstinence, as well as housing options for convicted felons and sex-offenders. Another gap in the system is the lack of funding to provide bus passes, or other means of transportation, in order to assist individuals in accessing services and appearing for scheduled appointments.

Additionally, there is a need for specialty providers to offer services to the older homeless population. These individuals are often discharged from hospitals and the criminal justice system without sufficient follow-up for services. As aging homeless individuals experience more barriers to accessing services, especially housing, spending more time in a state of homelessness, their health issues continue to deteriorate and symptoms of mental illness, such as depression, may result.

Furthermore, the number of homeless families appears to be on the rise, with a noticeable increase in cases involving domestic violence, especially when one or more members of the family has a mental health or substance abuse problem, therefore creating an increase in the number of homeless women with children. The lack of available services for this population is best illustrated by the increased number of homeless youth on the streets whose parent(s) are often substance abusers and/or mentally impaired.

Unfortunately, due to the current economic environment, homelessness is not expected to significantly decrease in future years.[23] However, Arizona will continue to address the needs of our system, including those identified above. Specifically, providers are assisting homeless individuals in locating transitional housing, helping clients apply for subsidized housing programs including Section VIII, and coordinating housing services such as motel vouchers, security deposits, application fees, and one-time only "Move-In, Keep-In" assistance. Providers are also forming close relationships with faith-based and other community organizations to offer wide range of social services to families, children, and single adults. These services include permanent supportive housing programs, family homeless shelters, eviction prevention/utility assistance funding, emergency motel stays, adoption and foster care services, referrals to local service agencies, food and clothing vouchers, and counseling services.

- *Individuals with mental and/or substance use disorders who live in rural areas*
The geographic diversity of Arizona requires ADHS/DBHS to maintain a service delivery network capable of providing behavioral health care not only to the 4th most populous county in the United States, Maricopa, which is also home to more than half of Arizona's residents, but also to the vast rural, frontier, and tribal reservations, within the state.

To accomplish this, ADHS/DBHS collects and reviews numerous data elements to measure the available inventories of treatment types across the states several geographic service areas (GSA), including the number of inpatient, outpatient, residential, and methadone providers operating in each region.[24]

In addition, ADHS/DBHS has the internal capacity to utilize geo-mapping technology to view the geographic location of various Provider Types within the state and regional areas in relation to enrolled adult and child members. In fiscal year 2011 the Annual Network Development Plan focused attention on the analysis of the geographic location of Behavioral Health Outpatient Clinics. Of the 35 different provider facility types, the Outpatient Clinic is the most utilized facility in both the urban and rural areas,

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[23] https://www.azdes.gov/InternetFiles/Reports/pdf/2010_homelessness_report.pdf

[24] The Network Inventory was included in the first section of this application.

especially due to ADHS/DBHS' ongoing commitment to treating individuals in the least restrictive community setting.

ADHS/DBHS used the results of this geo-mapping exercise to determine a statewide and GSA baseline of the percentage of enrolled consumers living within 15 miles from a Behavioral Health Outpatient Clinic. The following are observations from that analysis:

- Over 98% of the clients with a known street address (not homeless) reside within 15 miles of an outpatient clinic.
- Northern and Southeastern Arizona both have more than 5% of their clients living more than 15 miles from an outpatient clinic.
- There were 1,092 children and 2,245 adults (3,337 total) living more than 15 miles from an outpatient clinic statewide.

Although this analysis reflects sufficient placement of outpatient facilities across the state, and while approximately 50% of Arizona's substance abuse prevention coalitions are located in rural communities throughout Arizona, there is still a need to increase and enhance the availability of the full range of substance abuse treatment services in rural communities. Specifically, Northern Arizona counties tend to have higher rates of suicide and substance abuse behaviors, and emergency department visit rates for substance abuse were highest in Northern Arizona. Finally, in the rural counties there are few opportunities for advanced prevention trainings.

ADHS/DBHS has multiple initiatives designed to increase the quality and availability of service provision in the more rural areas of Arizona, including the expansion of ASIST trainings in Northern Arizona (Mohave, Apache, Navajo, Yavapai, Coconino Counties); conducting a needs, resource, and gap analysis of the Arizona-Sonora border region, and Increasing the availability and service utilization of Medication-Assisted Treatment (MAT) options, including Buprenorphine, Suboxone, Naltrexone, and Campral, among individuals with a substance use disorder.

- *Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines and enforcement.*

Arizona has several initiatives that address environmental prevention services. The Arizona Substance Abuse Partnership (ASAP) serves as the single statewide council on substance abuse prevention, enforcement, treatment and recovery efforts. The Communities Preventing Substance Abuse Work Group (CPSAWG) is a subcommittee of the ASAP, which functions as the State Policy Consortium for substance abuse prevention. CPSAWG addresses substance abuse concerns facing Arizona through collaboration with tribes, youth, law enforcement, governmental agencies, and community coalitions.

Arizonans for Prevention (AZFP) is Arizona's statewide Advocacy group for prevention. They are in the process of launching a statewide process for credentialing prevention professionals. They have a workforce development committee and a policy subcommittee. Two of the AZFP board members are also members of the CPSAWG.

The State Epidemiological Workgroup (SEOW) concluded that alcohol is the most costly and prevalent substance in Arizona and underage drinking should be a priority. Environmental conditions contributing to high rates of UAD include access via family and low the cost of alcohol.

In 2010, Arizona passed a law legalizing marijuana for medical use, this coincided with a sharp increase in rates of 30 day marijuana use among Arizona youths (Arizona Youth Survey, 2010).

Arizona's SEOW also concluded that prescription drug abuse is a priority due to increasing rates of poisoning fatalities and injuries (Arizona Epi Profile, 2009). Environmental conditions contributing to prescription drug abuse include: high availability, and high rates of prescribing.

While a number of Arizona communities have adopted social host laws in the past several years, communities need increased capacity to implement environmental strategies. Moving forward, the Division will continue to support efforts of AZFP, ASAP, and CPSAWG and provide technical assistance and training to Arizona coalitions to ensure they are able to adequately address environmental factors through prevention programs.

- ***Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and "late" adopters of prevention strategies***

Statewide there are approximately 80 coalitions whose primary focus is addressing substance abuse within their communities. Approximately 30% of these groups are either a current Drug Free Community (DFC) grantee or in the past five years, have been DFC, Strategic Prevention Framework State Incentive Grant (SPF-SIG), or a Weed and Seed coalition funded. In addition to these community based coalitions, the Division has approximately 50 subcontracted prevention programs which are required to be designed and planned through a community substance abuse prevention coalition.

Despite the comprehensive mental health and substance abuse prevention system operating in Arizona, there is still a need for further expansion and enhancements in various parts of the state. Specifically, in Pima County, a lack of advanced trainings based on current prevention science has contributed to a decreased acceptance of a coalition/community based approached to prevention services. Pima County is home to Arizona's second most populous urban environment (Tucson), and also has a significant rural population. Community-based prevention strategies are critical in areas such as this.

Accordingly, ADHS/DBHS will continue to collaborate and coordinate substance abuse prevention activities with the Community Prevention Substance Abuse Work Group (CPSAWG) and Arizona Substance Abuse Partnership (ASAP), and provide training and technical assistance to coalitions with priority given to coalitions in Graham, Gila, Mohave, and Pima Counties. Furthermore, it is our intention to increase the percentage of funded prevention programs which are incorporated into a community coalition as evidenced by a comprehensive community (coalition) strategic plan, and coordinate training and workforce development in evidence based practices.

System of Care Development

ADHS/DBHS synthesizes the various assessments, both for needs and capacity, and uses this information, along with legislative and contractual requirements to steer the development of the multiyear System of Care plans for Adults (ASOC) and Children (CSOC) served by the behavioral health service delivery network.[25]

In the spring and early summer of 2011, staff from the various functional units within ADHS/DBHS, peer and family members, and representatives from Family and Peer Run Organizations held meetings to determine the priority areas of focus for the next several state fiscal years and outlined numerous goals, objectives, and strategies necessary to improve system performance in these priority areas, which are as follows:

Children's System of Care
- Increase the percentage of children who live with their families;
- Increase the percent of youth who experience educational success;
- Increase the percent of youth who transition to a successful adulthood;
- Decrease youth substance use; and
- Decrease statewide rates of youth suicide completion.

Adult System of Care
- Enhance the physical health of all adult behavioral health recipients;
- Improve overall quality, effectiveness, and access to services, for individuals with a substance use disorder;
- Increase and retain employment of adult members served by the behavioral health system
- Reduce the overall suicide rate in Arizona;
- Integrate the Trauma Informed Care philosophy throughout all levels of the public behavioral health system;
- Increase the use of Peer and Family Support Services for all populations; and
- Promote the inclusion of community voices, and peer and family involvement, in all aspects of the public behavioral health system.

Importantly, while separated for ease of strategy development and strategic planning purposes, the above objectives are inherently related and largely interdependent of one another, as excelling in one area will likely lead to measurable improvements within others. For example, promoting the importance of Trauma Informed Care, or increasing the use of Peer and Family Support Services across the network is likely to contribute to a noticeable decline in suicides, as well and an increase in overall treatment effectiveness – as established by the National Outcome Measures.

Where appropriate and quantifiable, many of these priorities, or their measurable objectives, have been incorporated into this planning application and identified as State Priorities in Table 2, and further elaborated in Table 3.

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[25] The complete Children and Adult System of Care Plans are included as attachments at the end of this application

Anticipated Changes in Need Resulting from the Healthcare Reform Act

The State of Arizona has conducted and analysis of the estimated number of individuals who will be eligible for, and will participate in, the American Health Benefit Exchange (Individual Exchange) created under the Affordable Care Act and the increase in eligibility for services funded by the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program. As a result of this analysis, estimates have been made as to changes in the expected participation level in the state's public behavioral health system.[26]

ADHS/DBHS anticipates approximately 621,000 individuals in Arizona being eligible to participate in the Individual Exchange, and 94,000 newly eligible individuals qualified for Medicaid coverage through AHCCCS. At present, 337,000 uninsured individuals are currently eligible but not enrolled in AHCCCS.

However, of those with eligibility, we estimate 479,000 individuals seeking and obtaining coverage through the Individual Exchange; 196,000 or 41% of these individuals will have been previously uninsured. Furthermore, an additional 247,000 individuals will obtain coverage through AHCCCS, with 87% of this number being previously uninsured and therefore potentially higher, and more costly utilizers, of services.

Approximately 10% of those individuals eligible for services under AHCCCS typically seek behavioral health treatment provided by the Division's network – which would result in the Division serving an additional 24,700 Medicaid-eligible clients each year.

Moving forward, the focus of services paid through the block grants could potentially shift from the full behavioral health service array, and focus more on those services not covered through AHCCCS, such as prevention, certain crisis services, flex funds, room and board, and non-traditional/alternative medicines. Regardless, the Division will maintain priority funding and ensure placement for the grant-identified populations, prior to directing funds to non-Medicaid reimbursable services.

The mental health and substance abuse block grants will be available to cover behavioral health services for the remaining uninsured people and those who will not be covered by Medicaid after 2014, per the established formulary and as funding permits.

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[26] Please see http://www.azgovernor.gov/hix/documents/QuickLinks/BackgroundReport.pdf and http://www.azgovernor.gov/hix/documents/QuickLinks/BackgroundReport_Supplemental.pdf for more information on this analysis.

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities
Page 23 of the Application Guidance

Start Year:

End Year:

Number	State Priority Title	State Priority Detailed Description
1	Child and Adolescent Enrollment	Increase the number of youth identified as having a diagnosed substance use disorder.
2	Older Adult Enrollment	Increase outreach, engagement, and enrollment of adults over the ages of 55 with a diagnosed substance use disorder.
3	Service Provision to Members of the Military	Increase outreach, engagement, and enrollment of members of the military and their families.
4	Peer and Family Involvement	Promote the inclusion of community voices, and peer and family involvement, in all aspects of the public behavioral health system
5	Peer and Family Support Services	Increase the utilization of Peer and Family Support Services for all populations
6	Health Disparities	Decrease disparities in treatment outcomes (NOMS) across the various population subsets – including race/ethnic minority groups, the LBGTQ community, and age bands.
7	Health Integration	Increase Behavioral Health staff knowledge of health related topics and connection between physical and mental health
8	Suicide Prevention	Reduce the suicide rate in Arizona
9	Trauma Informed Care	Integrate the Trauma Informed Care philosophy throughout all levels of the public behavioral health system

| 10 | Medically Assisted Therapy | Increase the availability and service utilization of Medication-Assisted Treatment (MAT) options for individuals with a substance use disorder |
| 11 | Substance Abuse Treatment Placement (ASAM) | Ensure that consumers with a substance use disorder/dependence are referred and placed into the most appropriate treatment modality based on their clinical need by contractually mandating and implementing the statewide use of the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC). |

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators
Page 23 of the Application Guidance

Start Year:

2012

End Year:

2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
		ADHS/DBHS Will - • Standardize the process for screening youth for substance use disorders • Distribute pocket CRAFFT tools • Develop methodology for measuring utilization of the standardized screening instrument for substance use disorders • Host a web-based training on identification of youth with substance use disorders The RBHAs Will – • Develop a	Number of individuals	Providers are required to perform a clinical assessment for all behavioral health recipients at least annually, and submit client demographic information derived from these assessments to DBHS. In October of each year, client-level demographic data is extracted from the Client Information System (CIS) for those enrolled during preceding State Fiscal Year. Using this

| Child and Adolescent Enrollment | Increase the number of youth identified as having a diagnosed substance use disorder. | standardized, parent-friendly, screening tool to identify substance abuse in children and adolescents. • Collaborate and meet frequently with children/adolescent providers to provide information on substance abuse screening, trends, and best practices. • Provide or promote access to substance abuse training initiatives available to children/adolescent providers – including those employed through other agencies, such as Child Protective Services and Juvenile Justice. | enrolled in the behavioral health system, under the age of 18, who are diagnosed as having a substance use disorder or dependence. | information, ADHS/DBHS is able to determine unique client counts, by multiple population identifiers, i.e. age, race, gender, diagnosis, etc..., and compare client counts amongst these groups year-over-year to determine the percentage change in enrollment. Baseline: In Fiscal Year 2010, 4,618 youths, or 7.4% of those under the age of 18, in the behavioral health system were diagnosed as having a substance use disorder or dependence. Target: By the end of FY 2014, at least 9% of youths enrolled in the behavioral health system will be identified as having a diagnosed substance use disorder or dependence. |
| | | DBHS Will – • Complete a clinical guidance protocol for the treatment of older adults with a substance use disorder or dependence • Develop and provide an online training curriculum addressing engagement and treatment practices for older adults The | | |

| Older Adult Enrollment | Increase outreach, engagement, and enrollment of adults over the ages of 55 with a diagnosed substance use disorder. | RBHAs Will – • Require providers to add older adults as a population of focus in their outreach and engagement efforts (Cenpatico). • Design and Implement an Awareness Campaign specifically targeted to attracting older adults into treatment (NARBHA). • Develop and institute an online training program assisting providers in identifying and screening for substance abuse in the older adult population (Magellan). • Participate in the Behavioral Health and Aging Coalition monthly meetings attended by area agencies/providers working with older adults to collaborate on services available for older adults (CPSA). | Number of individuals enrolled in the behavioral health system, over the age of 55, who are diagnosed as having a substance use disorder or dependence. | Providers are required to perform a clinical assessment for all behavioral health recipients at least annually, and submit client demographic information derived from these assessments to DBHS. In October of each year, client-level demographic data is extracted from the Client Information System (CIS) for those enrolled during the preceding State Fiscal Year. Using this information, DBHS is able to determine unique client counts, by multiple unique population identifiers, i.e. age, race, gender, diagnosis, etc..., and compare client counts amongst these groups year-over-year to determine the percentage change in enrollment. Baseline: In Fiscal Year 2010, 5,838 individuals, or 8.3% of those with a substance use disorder or dependence were over the age of 55. Target: By the end of FY 2014, adults over the age of 55 will account for at least 11% of all individuals with a substance use disorder or dependence served by the public behavioral health system. |
| | | ADHS/DBHS Will – • Collaborate with the Arizona Coalition for Military Families, | | |

| Service Provision to Members of the Military | Increase the ability and comfort of behavioral health providers to offer culturally competent services for service members, veterans, and their families – ultimately resulting in an increased number of enrolled service members. | the VA, and stakeholders to develop an advanced training in cultural competency with military families for behavioral health providers • Provide access to the At-Risk training for families of veterans • Add a demographic data field to theADHS/DBHS Client Information System (CIS) to capture the veteran status of behavioral health recipients. The RBHAs Will - • Collaborate with the various Veterans' Affairs (VA) offices, and veteran advocacy groups, throughout the state to increase awareness amongst these organizations of services available to veterans and their families and seek feedback as to services that would be beneficial, but are currently not readily available. • Continue to incorporate the enhancement of culturally responsive care for members of the | The number of behavioral health recipients enrolled who indicate being a current or former member of the armed forces. Baseline to be established in Calendar Year 2012; subsequent performance will be expected to exceed that of the prior year. | Providers are required to perform a clinical assessment for all behavioral health recipients at least annually, and submit client demographic information derived from these assessments to ADHS/DBHS. In October of each year, client-level demographic data is extracted from the Client Information System (CIS) for those enrolled during the preceding State Fiscal Year. Using this information, ADHS/DBHS is able to determine unique client counts, by multiple unique population identifiers, i.e. age, race, gender, diagnosis, etc…, and compare client counts amongst these groups year-over-year to determine the percentage change in enrollment. Effective January, 2012, ADHS/DBHS will add a demographic data field to the Division's Client Information System (CIS) to capture the veteran status of all behavioral health recipients. This field will be the sole means of gathering and quantifying military member enrollment and assessing the State's outreach and engagement practices. |

military into
ongoing training
initiatives – Identify
subject matter
experts in this field.

ADHS/DBHS Will – •
Identify
opportunities for
collaboration
around integrated
health care and
health homes in
partnership with
Peer Member
Organizations and
the Arizona Peer
and Family
Coalition. •
Collaborate with
Peer and Family
Run Organizations
and Consumer
Advisory Councils
to develop a
mechanism to
inform service
recipients on how
to navigate the
changing Adult
Behavioral Health
System. • Implement
a statewide Peer,
Family and
Community
Member Quality
Involvement Survey
to measure
members' quality of
involvement on
committees,
advisory councils,
boards and
workgroups. •
Develop and deliver
training curriculum

Peer and Family Involvement

Promote the inclusion of community voices, and peer and family involvement, in all aspects of the public behavioral health system

(orientation training for peers and family members) that is inclusive of identified ADHS/DBHS approved core elements. • Promote activities which identify and develop peer and family advocacy and leadership opportunities. • Market presentations to colleges and universities to increase awareness of Recovery, Stigma and Community Integration. • Develop strategies to increase opportunities for internships within the Division. • Monitor Service Plans for inclusion of natural and community supports/activities that foster community integration (i.e., gyms, parks and recreation programs, non-credit internet classes, YM/WCA, libraries, volunteer opportunities, etc.). The RBHAs Will – • Continue ongoing

The Statewide number of peer and family members actively participating on behavioral health workgroups, committees, advisory boards, panels, and policy-making bodies.

As part of the annual network inventory, and System of Care (SOC) updates, each RBHA provides ADHS/DBHS with the names of all Peer and Family members participating on their numerous functional committees and policy-making bodies, which committee(s) each individual serves on, the primary charge of said committee, and the frequency in which the committee meets. Examples of these committees includes: • Governance Board; • Quality Improvement Committee; • Utilization Management Committee; • Pharmacy and Therapeutics Committee; • Cultural Competency; • Customer Service, and; • Human Rights On an annual basis, ADHS/DBHS will review RBHA submissions and determine if the RBHAs are increasing the number of Peers and Family members participating on their committees and offer technical assistance where necessary. Fiscal Year 2011 participation was as follows per RBHA: Magellan – 21 Peer and Family Members CPSA – 40 Peer and Family Members NARBHA – 67 Peer and Family Members

recruitment / awareness efforts to increase participation and representation • Continue to provide stipends to all member/family member participants as long as budget allows. • Maintain peer and family support roles throughout the provider network according to need and available funding, and follow up with provider agencies that experience a decrease in peer and family support roles to ensure capacity is re-established. • Collaborate with family-run organizations and provider agencies to develop a mechanism for identifying youth and family leaders that can be engaged in leadership activities across all levels of the system.

ADHS/DBHS Will - • Promote education for youth and families on the availability of family and peer support

services. • Promote opportunities for collaboration between peer-run and family-run organizations. • Standardize minimum competencies for peer delivered family support by: - Reviewing the National Federation of Families (NFF) proposed competencies for peer-delivered family support and incorporate the NFF competencies in the development of minimum state standards for Arizona's peer-delivered family/youth support positions, training and supervision needs. - Identifying one family leader from each Family Run Organization and

| Peer and Family Support Services | Increase the use of Peer and Family Support Services for all populations | one family leader from ADHS/DBHS to complete the NFF credentialing process for national certification in peer-delivered family support competencies. • Discuss the importance of Peer and Family support services as it relates to treatment engagement and retention during meetings with the TRBHAs and their providers, and identify opportunities for expanding these services as necessary. • Support the T/RBHA's and Peer and Family Run Organizations in the development of a mechanism for Behavioral Health recipients to self refer for Peer and Family Support Services The RBHAs Will - • Monitor utilization and provide TA to those providers with low Peer and Family Support utilization. • Coordinate a Peer and Family Run Organization Fair for peers and family | The number of individuals who receive Peer and/or Family support services as part of their treatment regimen. | Utilization rates and service penetration will be based on encounter claim data. Each year client level demographic and encounter data is extracted from the ADHS/DBHS Client Information System (CIS). Using this information, the Division is able to determine 1) the number of individuals enrolled in the public behavioral health system within a given period of time, and; 2) the number of these individuals who received Peer and/or Family support services as part of their treatment regimen during the time frame in question. Baselines will be established in October, 2011, using fiscal year 2011 utilization data. The following groups will be assessed separately: • Individuals with a Substance Use Disorder or Dependence • Children and Adolescents • Adults with a Serious Mental Illness ADHS/DBHS has set a goal of improving Peer and/or Family service utilization by at least 5% annually for each of the above populations. |

members to learn about these programs and their services (CPSA). • Create a list of information on Peer and Family Run Organizations with program highlights to be distributed to clinic case managers, customer service and grievance & appeals staff.

ADHS/DBHS Will – • Conduct an annual review of treatment outcomes (NOMs) for all adult behavioral health recipients with a substance use disorder. • Analyze treatment outcomes data, separating population groups by gender, race/ethnicity, age band, sexual identity, and sexual orientation. • Compare the outcome performance of the above population subsets to those of the total adult substance abusing population. • Present findings to

Providers are required to perform a clinical assessment for all behavioral health recipients at least annually, and submit client demographic information derived from these assessments to ADHS/DBHS. This assessment gathers information such as i.e. age, race, gender, diagnosis, etc…, as well as the necessary data used to determine the client's status on the National Outcome Measures. In October of each year, this client-level demographic data is extracted from the Client Information System (CIS) for those enrolled during the preceding State Fiscal Year. Using this information, ADHS/DBHS performs a

Health Disparities	Decrease disparities in treatment outcomes (NOMs) across the various substance-using population subsets – including race/ethnic minority groups, the LBGTQ community, and age bands.	the RBHAs when available and require them to address any identified performance discrepancies (root cause analysis). Once rates have been established by ADHS/DBHS, the RBHAs Will – • Identify disparities in service provision amongst populations not realizing comparatively positive outcomes, including the need for enhanced culturally-responsive care to these groups where appropriate. • Review NOM performance on a routine basis and disseminate results across the various functional groups (Quality Management, Network, Grievance and Appeals, etc…) for feedback and potential policy revisions.	Change in client status from intake to update/closure on the National Outcome Measures, analyzed for the total adult substance abusing population, and separately by Race/Ethnicity, Gender, Age Band, and LBGTQ.	comprehensive outcomes performance analysis comparing each client's NOM status at intake (pre-treatment) to that of assessment update or treatment discharge (mid/post-treatment) in order to determine if the funded programs are producing positive quality of life changes for those in treatment (increased employment, increased school participation, decreased criminal activity, decreased substance use, and decreased instances of homelessness). Once the overall treatment population has been reviewed and their performance documented, the data is split by population subsets (by race, age band, gender, etc…), and NOMS are reviewed within these unique groups, compared amongst one another, and then against the total population, in an effort to identify groups who may be experiencing disparate outcomes relative to the larger population. Baseline: To be established in November, 2011, using Fiscal Year 2011 client data. Target: Once baseline has been established, future annual performance for each outcome, within each population subset, should exceed the performance of the past fiscal year.
		ADHS/DBHS Will – • Conduct an online training series on co-occurring physical and mental health condition among Behavioral		

| Health Integration | Increase Behavioral Health staff knowledge of health related topics and connection between physical and mental health, and improve the coordination of care between behavioral health providers and the recipient's Primary Care Physician. | Health recipients, including specialized topics for peer and family support providers. • Implement Quarterly Health Initiatives (QHIs) focused on the interrelationship between acute and behavioral health care and the importance of addressing both to promote whole health recovery. • Monitor the RBHAs' Coordination of Care performance on a quarterly basis and provide technical assistance when performance falls below the contractually-established minimum standards. The RBHAs Will - • Educate acute health plans on substance abuse providers available within the provider network and referral processes. • Invite medical community to attend mental health first aide training. • Provide all ER and FQHC clinics education on referrals to services in the | Behavioral Health Service providers communicate with and attempts to coordinate care with the Behavioral Health Recipient's acute health plan/PCP | ADHS/DBHS performs a random sample case file review on a quarterly basis and documents whether or not the file under review contains evidence that the behavioral health attempted to coordinate care with the recipient's acute health plan and/or Primary Care Physician. Numerator: Number of sample records containing documentation of coordination of care, including all required elements of documentation. Denominator: Number of sample records Target: ADHS/DBHS has established a contractual Minimum Performance Standard (MPS) with the RBHA's requiring 85% compliance for the Coordination of Care metric - with a goal of eventually achieving 95% compliance. |

network (Cenpatico). • Form a wellness committee with representation from provider networks, members and families. Committee members are expected to contribute to the development and distribution of health promotion information to system partners (CPSA). • Convene Health and Wellness Committee meetings with SMI providers, GMH/SA providers and other key stakeholders on a monthly basis (Magellan).

ADHS/DBHS Will – • Increase comfort and ability of families and communities to identify potential risk and make referrals to BH treatment. • Provide training for service members, veterans, and their families in recognizing signs of PTSD and TBI and the referral process. • Provide online training for college professors

| Suicide Prevention | Reduce the suicide rate in Arizona | and students in identifying and referring persons potentially at-risk. • Collaborate with the Department of Economic Security in distributing awareness materials • Increase the comfort and ability of poison control center staff to intervene with attempters and make referrals to BH treatment • Develop ADHS/DBHS recommendations for responding to and providing services after a suicide • Collaborate with the Statewide Suicide Prevention Coalition, Statewide Injury Prevention Coalition, and the Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) Advisory Committee • Conduct Arizona Dialogues on issues surrounding suicide • Incorporate efforts to expand the utilization of natural supports in | The suicide rate in Arizona is to decrease from 16.1 per 100,000 persons (age adjusted) to 14.0 per 100,000 persons. | Each fall, the Arizona Department of Health Services, Division of Public Health and Statistics (ADHS/PHS) calculates the State's suicide rate by determining the number of death certificates of Arizona residents where "Suicide" was indicated by a medical examiner as the cause of death during the second most recent complete calendar year (i.e. CY 2010 data will be made available in fall 2011). This number is then aggregated across the general population to establish a suicide rate per 100,000 persons. This information is then published on the ADHS/PHS website for public dissemination (see http://www.azdhs.gov/plan/report/ahs/index.htm) |

providers Practice Improvement Plans • Promote the use of Teen Life Line and other community-based organizations focused on teen suicide prevention via the use of ADHS/DBHS multi-media The RBHAs Will – • Provide Mental Health First Aid (MHFA) and Applied Suicide Intervention Strategies Training (ASIST) Trainings to peers, family members, first responders, and coalition groups. • Meet with poison control to identify needs and provide training, technical assistance, and/or resources (where available) • Implement the Lock -in Program to reduce incidents of inappropriately acquired controlled substances via doctor shopping or pharmacy hopping (Magellan)

ADHS/DBHS Will – • Conduct statewide TIC Dialogues to create awareness and assess community needs

| Trauma Informed Care | Integrate the Trauma Informed Care (TIC) philosophy throughout all levels of the public behavioral health system. | around trauma informed care. • Develop a formal Trauma Informed Care Needs Assessment based on these dialogues • Provide training and education on trauma and trauma informed care across system. • Develop a plan to incorporate TIC in human resource practices, policies, procedures, and other tools. • Incorporate the use of social media and other venues to increase public knowledge and awareness of trauma informed care. • Increase partnerships with CSAs to educate, advocate, and support trauma informed care. The RBHAs Will - • Provide / host Trauma Informed Care (TIC) dialogues throughout the State. • Provide technical assistance and support trauma literacy campaigns (i.e. media stories, news articles, social media) to increase awareness and | Pre and Post Test survey results to determine provider familiarity with the tenants of Trauma Informed Care and the importance of its integration. | Performance will be measured through multiple means, including: 1. A Pre and Post-Test Survey to determine provider and community familiarity with the tenants of Trauma Informed care and the importance of its integration into treatment planning. 2. Ongoing tally of the numbers of individuals (providers and community members) attending the TIC trainings and dialogues (numbers should increase on an annual basis). 3. Other metrics will be based on the statewide TIC needs assessment – baselines to be established in Fiscal Year 2012. |

prevalence of trauma aimed at behavioral health staff, members/families, system partners, and community members. • A Trauma Informed Care Subject Matter Expert to present to System of Care staff, peer and family members, behavioral health providers, and Community Service Agencies. • Develop on-line training initiatives around Trauma Informed Care for behavioral health providers.

ADHS/DBHS Will - • Institute a pilot program using SAPT Block Grants funds for Medication Assisted Substance Use Treatment for non-methadone MAT alternatives. • Monitor service utilization data for the number of individuals receiving Buprenorphine, Suboxone, Campral, Naltrexone, and Methadone. •

| Medically Assisted Therapy | Increase the availability and service utilization of Medication-Assisted Treatment (MAT) options for individuals with a substance use disorder. | Monitor network capacity / network inventory for the number of providers licensed and permitted to prescribe non-methadone MAT drug types to determine adequacy and identify gaps if present. The RBHAs Will - • Institute a pilot program specifically focused on providing non-methadone MAT to SAPT-qualifying individuals. This pilot is to operate throughout State Fiscal Year 2012. • Implement a new Responsible Agency (RA) provider for specialized SA services which include opioid replacement services across the network (NARBHA). • Based on the results of these pilots, establish target increases and confer with providers to identify possible MAT candidates. | The number of individuals with a substance use disorder or dependence (SUD) who receive Medically Assisted Therapy as part of their treatment regimen. | Utilization rates and service penetration will be based on encounter claim data. Each year client level demographic and encounter data is extracted from the ADHS/DBHS Client Information System (CIS). Using this information, ADHS/DBHS is able to determine 1) the number of individuals enrolled in the public behavioral health system within a given period of time; 2) of this population, the number of individuals who have an AXIS I.1 - I.5 diagnosis congruent to a substance use disorder or dependence, and; 3) the number of these individuals who underwent some form of Medically Assisted Therapy (MAT) as part of their treatment regimen. The most recent review of this data, based on calendar year 2010, indicated that 9.3% or 93.32 per 1,000 individuals with a substance use disorder/dependence utilized MAT services. The Division has set a goal of improving MAT penetration and utilization by at least 2% annually. |
| | | ADHS/DBHS Will - • Host monthly learning community meetings with the | | |

Substance Abuse Treatment Placement (ASAM)	Ensure that consumers with a substance use disorder/dependence are referred and placed into the most appropriate treatment modality based on their clinical need by contractually mandating and implementing the statewide use of ASAM-PPC	State's certified ASAM trainers to discuss lessons learned and assess their needs. • Communicate with representatives from The Change Company as necessary and prudent to ensure ASAM-PPC is implemented effectively and appropriately. • Assist the RBHAs in creating on-line ASAM trainings, or webinars, on ASAM-PPC to expidite staff training for non-interactive lecture materials. The RBHAs Will - • On a quarterly basis, report the number of provider staff participating in, and completing, training for ASAM-PPC and submit training session sign-in sheets. • Provide ASAM training to all clinical staff performing assessments on the adult population – having 90% of this group trained no later than June 30, 2012. • Revise the lecture portion of the ASAM training, with the approval	The percentage of providers' staff members who successfully complete the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC)	As required by the Adult System of Care plan (ASOC), on a recurring basis each RBHA must report their progress in training provider staff on the tenants and appropriate use of the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC). The Division has set a goal of 90% compliance by the end of June 2012 and this rate must be maintained at a minimum in all subsequent years. ADHS/DBHS has acknowledged that it will be difficult to achieve 100% compliance due to staff turnover; however, ASAM-PPC training must be provided to all new employees who conduct behavioral health assessments upon their hiring.

of The Change
Company, into a
web-based format
to more efficiently
facilitate clinician
trainings. • Train
Quality
Management /
Utilization
Management Staff
on ASAM to ensure
proper oversight
and monitoring of
the ASAM Patient
Placement Criteria.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy
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Start Year:

End Year:

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	Encounter-based services include, yet are not limited to (please see footnote): Behavioral Health Counseling and Therapy; Assessment, Evaluation and Screening Services; Skills Training and Development; Psychosocial Rehabilitation Living Skills Training; Cognitive Rehabilitation; Health Promotion; Psychoeducational Services & Ongoing Support to Maintain Employment; Medication Services and Medication Management; Case Management; Personal Care Services; Peer Support; Home Care Training; Unskilled Respite Care; Supported Housing; Transportation; Crisis Services (Mobile, Stabilization, and Telephone); Inpatient Services (Hospital, Sub-acute, and Residential Treatment Center); Residential Services (Short and Long Term; with and without Room and Board); Supervised and Therapeutic Behavioral Health Treatment & Day Programs; Community Psychiatric Supportive Treatment, and; Medical Day Programs.
Grant/contract reimbursement	Prevention Services: Services for persons who do not need treatment, designed to affect knowledge, attitude or behavior, and; HIV Early Intervention Services

Footnotes:

The complete ADHS/DBHS covered services guide can be accessed at http://www.azdhs.gov/bhs/pdf/CovBHsvsGuide.pdf

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SAPT - Services Purchased Using Reimbursement Strategy
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Start Year:

2012

End Year:

2013

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	Encounter-based services include, yet are not limited to (please see footnote): Behavioral Health Counseling and Therapy; Assessment, Evaluation and Screening Services; Skills Training and Development; Psychosocial Rehabilitation Living Skills Training; Cognitive Rehabilitation; Health Promotion; Psychoeducational Services & Ongoing Support to Maintain Employment; Medication Services and Medication Management; Case Management; Personal Care Services; Peer Support; Home Care Training; Unskilled Respite Care; Supported Housing; Transportation; Crisis Services (Mobile, Stabilization, and Telephone); Inpatient Services (Hospital, Sub-acute, and Residential Treatment Center); Residential Services (Short and Long Term; with and without Room and Board); Supervised and Therapeutic Behavioral Health Treatment & Day Programs; Community Psychiatric Supportive Treatment, and; Medical Day Programs.
Grant/contract reimbursement	Prevention Services: Services for persons who do not need treatment, designed to affect knowledge, attitude or behavior, and; HIV Early Intervention Services

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 CMHS - Projected Expenditures for Treatment and Recovery Supports
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Start Year: [   ]

End Year: [   ]

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	N/A
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	<10%
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	<10%
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	10-25%
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	26-50%
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	<10%
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	10-25%

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	<10%
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	10-25%
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	<10%
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	10-25%
System improvement activities		N/A
Other		N/A

Footnotes:

Projections are based on the average utilization per service type for State Fiscal Years 2009 and 2010 as a percentage of all services provided.

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 SAPT - Projected Expenditures for Treatment and Recovery Supports
Page 30 of the Application Guidance

Start Year: [   ]
End Year: [   ]

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	N/A
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	<10%
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	<10%
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	10-25%
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	26-50%
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	<10%
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	10-25%

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	<10%
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	10-25%
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	<10%
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	10-25%
System improvement activities		N/A
Other		N/A
Footnotes:		

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 CMHS - Primary Prevention Planned Expenditures Checklist
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Start Year: [   ]
End Year: [   ]

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$	$ 50,000	$	$	$
Information Dissemination	Selective	$	$ 19,500	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$	$69,500	$	$	$
Education	Universal	$	$ 78,970	$	$	$
Education	Selective	$	$ 29,250	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$	$108,220	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Selective	$	$ 243,250	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$	$243,250	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$	$	$	$	$

Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$	$	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$	$	$	$

Footnotes:

Other Federal Funding: Arizona Suicide Prevention Grant

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 SAPT - Primary Prevention Planned Expenditures Checklist
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Start Year: [   ]

End Year: [   ]

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$ 332,008	$	$	$	$
Information Dissemination	Selective	$ 738	$	$	$	$
Information Dissemination	Indicated	$ 738	$	$	$	$
Information Dissemination	Unspecified	$ 0	$	$	$	$
Information Dissemination	Total	$333,484	$	$	$	$
Education	Universal	$ 1,106,692	$	$	$	$
Education	Selective	$ 368,897	$	$	$	$
Education	Indicated	$ 73,779	$	$	$	$
Education	Unspecified	$ 0	$	$	$	$
Education	Total	$1,549,368	$	$	$	$
Alternatives	Universal	$ 368,897	$	$	$	$
Alternatives	Selective	$ 295,118	$	$	$	$
Alternatives	Indicated	$ 73,779	$	$	$	$
Alternatives	Unspecified	$ 0	$	$	$	$
Alternatives	Total	$737,794	$	$	$	$
Problem Identification and Referral	Universal	$ 221,338	$	$	$	$
Problem Identification and Referral	Selective	$ 73,779	$	$	$	$
Problem Identification and Referral	Indicated	$ 2,213	$	$	$	$
Problem Identification and Referral	Unspecified	$ 0	$	$	$	$
Problem Identification and Referral	Total	$297,330	$	$	$	$

Community-Based Process	Universal	$ 1,844,486	$	$	$	$
Community-Based Process	Selective	$ 368,897	$	$	$	$
Community-Based Process	Indicated	$ 33,201	$	$	$	$
Community-Based Process	Unspecified	$ 0	$	$	$	$
Community-Based Process	Total	$2,246,584	$	$	$	$
Environmental	Universal	$ 1,475,589	$	$	$	$
Environmental	Selective	$ 737,795	$	$	$	$
Environmental	Indicated	$ 0	$	$	$	$
Environmental	Unspecified	$ 0	$	$	$	$
Environmental	Total	$2,213,384	$	$	$	$
Section 1926 Tobacco	Universal	$ 72,175	$ 64,550	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$72,175	$64,550	$	$	$
Other	Universal	$	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$	$	$	$

Footnotes:

1) Section 1926 Tobacco, Column SAPT Block Grant , is Synar inspections with Community Bridges & Pima Prevention Partnership (PPP). Fund Source: SAPT Prevention (Index 99148) $40,000 & SAPT Admin (Index 99143) $32,175
2) Section 1926 Tobacco, Other Federal Column, is FDA inspections with Community Bridges ($32,275) & PPP ($32,275). Fund Source: FDA Grant, Index 92143.

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 CMHS - Projected State Agency Expenditure Report
Page 38 of the Application Guidance

Start Year: [   ]
End Year: [   ]

Date of State Expenditure Period From: [10/01/2011]   Date of State Expenditure Period To: [09/30/2013]

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$	$	$	$	$	$
2. Primary Prevention	$	$	$ 425,000	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$ 4,375,000	$	$ 86,450,000	$ 17,849,100	$
6. Other 24 Hour Care	$ 638,209	$ 318,667,309	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$ 8,479,057	$ 1,500,295,756	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$ 479,856	$ 20,679,917	$ 398,897	$ 1,136,377	$	$ 374,500
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$479,856	$20,679,917	$823,897	$1,136,377	$	$374,500
10. Subtotal (Rows 5, 6, 7, and 8)	$9,597,122	$1,844,017,982	$398,897	$87,586,377	$17,849,100	$374,500
11. Total	$9,597,122	$1,844,017,982	$823,897	$87,586,377	$17,849,100	$374,500

Footnotes:

* Numbers reflect a 21 Month Expenditure Projection (October 1, 2011 - June 30, 2013) to coincide with the grant's planning period.
* "Other 24 Hour Care" includes Community Mental Health Inpatient

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 SAPT - Projected State Agency Expenditure Report
Page 38 of the Application Guidance

Start Year: [   ]
End Year: [   ]

Date of State Expenditure Period From: 10/01/2011   Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$ 27,817,294	$ 110,891,435	$	$ 87,500	$ 2,957,274	$
2. Primary Prevention	$ 7,417,945	$	$ 140,000	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$ 1,854,486	$ 10,522,280	$ 228,272	$ 14,967	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$37,089,725	$121,413,715	$368,272	$102,467	$2,957,274	$
10. Subtotal (Rows 5, 6, 7, and 8)	$1,854,486	$10,522,280	$228,272	$14,967	$	$
11. Total	$37,089,725	$121,413,715	$368,272	$102,467	$2,957,274	$

Footnotes:

* Numbers reflect a 21 Month Expenditure Projection (October 1, 2011 - June 30, 2013) to coincide with the grant's planning period.
* "Other 24 Hour Care" includes Community Mental Health Inpatient

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist
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Start Year: [   ]

End Year: [   ]

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	$	$ 160,517	$	$		$160,517
2. Quality Assurance					$ 391,404	$391,404
3. Training (Post-Employment)	$	$ 645,285	$	$		$645,285
4. Education (Pre-Employment)	$	$ 60,959	$	$		$60,959
5. Program Development	$	$ 309,576	$	$		$309,576
6. Research and Evaluation	$	$ 748,985	$	$		$748,985
7. Information Systems	$	$ 235,559	$	$		$235,559
8. Total	$	$2,160,881	$	$	$391,404	$2,552,285

Footnotes:

1) % of T/RBHA prevention budget reflects 30% of overall SAPT funding.

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services
Page 41 of the Application Guidance

<u>Narrative Question:</u>

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

ADHS/DBHS supports a model for assessment, service planning, and service delivery that is strength-based, family friendly, culturally sensitive and clinically sound and supervised. The model is based on three equally important components: input from the person and family/significant others regarding their special needs, strengths and preferences; input from other individuals who have integral relationships with the person; and clinical expertise.

The model incorporates the concept of a "team", established for each person receiving behavioral health services. At a minimum, the team consists of the person, family members in the case of children, and a qualified behavioral health clinician. As applicable, the team would also include representatives from other state agencies, clergy, other relevant practitioners involved with the person and any other individuals requested by the person. In addition, the model is based on a set of clinical, operative and administrative functions, which can be performed by any member of the team, as appropriate. At a minimum, these include:[1]

- An initial assessment process performed to elicit strengths, needs and goals of the individual person and his/her family, identify the need for further or specialty evaluations that support development of a service plan which effectively meets the person's needs and results in improved health outcomes;
- Ongoing engagement of the person, family and others who are significant in meeting the behavioral health needs of the person, including active participation in the decision-making process;
- Continuous evaluation of the effectiveness of treatment through the ongoing assessment of the person and input from the person and his/her team resulting in modification to the service plan, if necessary;
- Provision of all covered services as identified on the service plan that are clinically sound, including referral to community resources as appropriate and, for children, services which are provided consistent with the Arizona vision and principles;
- Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of covered services is important to achieving positive outcomes, (e.g., primary care providers, school, child welfare, juvenile or adult probations, other involved service providers), and;
- Development and implementation of transition plans prior to discontinuation of behavioral health services.

Services for individuals and their support systems that are self-directed:
ADHS/DBHS spearheaded two whole health peer-based initiatives to offer whole health services to members in Maricopa and Pima counties. Both initiatives consisted primarily of education and peer based support, teaching topics such as nutrition, exercise, healthy habits, and many others. Pilot participants were measured at the beginning of the program and routinely to monitor weight loss, lifestyle changes, body mass index, blood pressure, etc. Members are also encouraged to communicate/ask questions to their PCPs regarding the health topics they are learning about and the lifestyle changes they are experiencing or committing to make. This initiative was funded through a Transformation Transfer Initiative grant from SAMHSA and NASMHPD. The grant funding pilot period ended in March 2011, but both programs have continued to grow and become sustainable through other funding sources. There is also a peer-based whole health program in Pinal County.

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[1] Please see the ADHS/DBHS Provider Manual Section 3.9 for more details on assessment and service planning, available at http://www.azdhs.gov/bhs/provider/sec3_9.pdf .

In addition, ADHS/DBHS implemented its *Quarterly Health Initiative (QHI),* a program to educate consumers and providers on particular physical health topics affecting the behavioral health population. Through "QHI Kit" materials, consumers are prompted to ask health related questions to their behavioral health provider during their next visit. The QHI Kit materials at the same time provide behavioral health providers education to answer health related questions asked by the consumer and/or provider appropriate material referral to a specialist or PCP.

What supports does your state offer to assist individuals to self-direct their care:
Peer and Family support partners/specialists assist service recipients and their family members in understanding the service planning process and their responsibilities in developing a service plan that meets their needs. Additionally, Warm Lines staffed by peers and family members provide reminders that the service recipient should take ownership of their treatment and can connect callers to natural supports within their own communities. Furthermore, peer/family organizations provide workshops and groups on self-determination, self-advocacy, WRAP planning and leadership development programs.

IV: Narrative Plan

E. Data and Information Technology
Page 41 of the Application Guidance

Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

ADHS/DBHS incorporates client demographic and service utilization data into its daily management, administrative and oversight operations and encourages data-driven decision making throughout all levels of the provider network to improve the quality and timeliness of service delivery.

ADHS/DBHS maintains a Client Information System (CIS), which is comprised of three interdependent databases used for storing client eligibility, demographic, and service encounters information. The three systems utilize a unique identifier (CIS ID) as a primary key for joining, and operate as follows:

Enrollment and Eligibility
All clients receiving services must be enrolled in the behavioral health system under one of the defined eligibility categories (State-Only or Medicaid Eligible). The Enrollment and Eligibility database maintains the historical enrollment segments for all clients – based on a HIPAA-compliant 834 submission.[1] The database allows the Division to determine, and subsequently report, the number of enrolled Medicaid eligible clients, compared to those who would otherwise be funded through other means, including State General Funds, or Federal Block Grants (for more information please see the *Client Information System File Layout Manual*, available at http://www.azdhs.gov/bhs/gm.htm).

Demographics
ADHS/DBHS policy requires that all behavioral health consumers who remain enrolled in the system for at least 45 days undergo a clinical assessment, administered by a clinician at the provider level. Among the data gathered during this process are several identifiable factors, such as date of birth, race and ethnicity, gender, DSM-IV Axial Diagnoses, National Outcome Measures (NOMs), and reasons for seeking treatment. Furthermore, this information must be updated on an annual basis, at a minimum, or upon a significant change in the client's life - such as gaining employment, or reporting an extended period of substance use abstinence. Lastly, a final assessment of the client is required upon completion of the treatment episode (for more information please see the *Demographic and Outcome Data Set User Guide*, available at http://www.azdhs.gov/bhs/gm.htm).

Service Encounters
Client service encounter data is also reported by the provider network, and is required to be submitted to ADHS/DBHS no later than 210 days following the date of service. This information includes the type of service being provided, i.e. group counseling, case management, or a clinical assessment, the number of service units the client received in a unique session (typically based on 15 minute increments, or per-diem, depending on service type), the total dollar value for that service session, and the provider offering the service. This reporting standard allows ADHS/DBHS to measure service utilization, by service type and provider, at the client level; in other words, ADHS/DBHS can report the precise number of service units, and the corresponding dollar value, each consumer received, or each agency provided, within a given timeframe. The encounters database also contains prescription drug utilization information (for more information, please see the *Covered Behavioral Health Services Guide*, available at http://www.azdhs.gov/bhs/gm.htm).

The data housed within the Client Information System is vital to ADHS/DBHS' ongoing efforts to ensure the RBHAs and providers are offering services designed to achieve programmatic goals in a manner that is both effective and resource efficient, while determining if behavioral health consumers are moving towards recovery.

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[1] As of 10/1/2010 all Medicaid-eligible clients are also enrolled in the public behavioral health system and may access services without the need of a separate 834-HIPAA enrollment.

EHR implementation is ongoing throughout the state, with many direct service providers using some form of electronic system for maintaining and sharing medical records. The complexities of these systems vary by region, volume of individuals served, and the spectrum of services offered by each provider. To date, the State has focused efforts on streamlining data collection, including the elimination of erroneous or unnecessary data elements from the required information to be collected.

As applicable, for each of these systems, please answer the following:

- **For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?**

Yes – Providers are required to obtain a National Provider Identification (NPI) number and submit this ID on all service encounter transactions. The Client Information System (CIS) collects and stores the NPI. System standards (CIS) require the NPI to meet the specifications detailed in the Final Rule for the Standard Unique Health Identifier for Health Care Providers (69 FR 3434) – published on January 23, 2004.

- **Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?**

Yes – Other than the National Provider Identification number, the system also delineates provider organizations by service facility, or licensure type, i.e. Outpatient, Residential, Hospital, Sub-Acute, Crisis, etc… Furthermore, each provider is assigned a unique ID by the State's Medicaid Authority and data can be aggregated / delineated by this ID as well.

- **Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?**

Yes – the Client Information System uses a unique client identifier, referred to as the "CIS ID", to provide unduplicated counts of clients and the ability to aggregate services by client, as well as identify all clients receiving a particular service. The CIS ID serves as a primary key, linking the Encounters, Enrollment, and Demographic databases.

- **Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?**

Yes – when providers submit encounter claims they must include their NPI, the Client ID, the service type (based on HICFA procedure code), the start and end date of service, the number of units provided, and the total cost of service. This information is stored within the encounters database maintained by the ADHS/DBHS.

- **Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?**

In Progress – the system is currently undergoing the required upgrades to comply with the HIPAA 5010 standard. Upon completion, work will begin in transitioning to the ICD-10 format.

- **Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?**

Yes – while the majority of providers in Arizona's public behavioral health system serve both Medicaid and non-Medicaid clients, the IT infrastructure allows reviewers to identify and compare service provision between Medicaid and Non-Medicaid providers, as well as the services provided to Medicaid-eligible clients in comparison to their Non-Medicaid-eligible counterparts.

- **Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?**

In Progress – ADHS/DBHS serves as the behavioral health "carve out" for the State's Medicaid authority, the Arizona Health Care Cost Containment System (AHCCCS). The two agencies are progressing towards a standard of bi-directional information sharing whereas DBHS would be permitted access to the Acute Health information for behavioral health recipients.

- **Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system OMB No. 0930-0168 40 interoperability, electronic health records, Federal IT requirements or similar issues?**

Yes – staff from the Department of Health Services' Information Technology Services (ADHS/ITS) confers bi-weekly with their counterparts at the Arizona Health Care Cost Containment System (AHCCCS), the State's Medicaid authority. These meetings focus on system interoperability and compatibility, processing 834-HIPAA enrollment, and 837 encounters records, and system transition toward HIPAA 5010 and ICD-10 formatting standards.

- **Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?**

Yes – the Arizona Office of the Governor, in collaboration with the Arizona Health Care Cost Containment System (AHCCCS), the State's Medicaid authority, have been awarded a Health Information Technology and Exchange Planning Grant (EP-HIT-09-001) and are currently working to implement the identified operational plan necessary to meet the grant requirements. The current plan focuses on acute care services, not Mental Health or Substance Abuse; therefore, the Arizona Department of Health Services, Division of Behavioral Health Services is not an active HIE/HIT participant at this time.

- **Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?**

All major enhancements to the Medicaid IT system are temporarily on hold pending successful transition to the HIPAA 5010 transmission standards. However, the *Arizona Health Care Cost Containment System and the Division of Behavioral Health Services are taking steps to promote bi-directional information sharing in relation to individuals who are receiving both behavioral health and acute care services in Arizona.*

IV: Narrative Plan

F. Quality Improvement Reporting
Page 43 of the Application Guidance

Narrative Question:
SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

The Bureau of Quality Management Operations (BQMO) works collaboratively with all functional areas of ADHS/DBHS in the ongoing assessment and evaluation of the quality of services provided to behavioral health recipients. Quality Management (QM) administrative oversight and communication activities are conducted through ADHS/DBHS' committees and by sharing data amongst the various functional areas. The several committees are utilized for decision making, performance monitoring, development of performance improvement activities, and as a means for incorporating stakeholder and member feedback into QM activities.

ADHS/DBHS follows the Plan, Do, Study, Act (PDSA) Quality Improvement cycle to evaluate data, assess performance, test interventions and refine activities as necessary. Through its contracts, ADHS/DBHS mandates the use of the PDSA model in every contractor's QM activities. To that end, ADHS/DBHS developed a standardized QM Report Template and a QM Corrective Action Plan (CAP) Template that incorporates the tenets of this model to assist in the continuous assessment and evaluation of system performance.

Appropriately, the 2010-2011 Quality Management Plan is designed to achieve improved quality of care for behavioral health recipients utilizing evidenced-based best practices. Activities defined to support QM processes and program goals are delineated in the QM Work Plan. These activities serve to direct and focus the QM program and include clearly defined goals, measurable objectives, data feeds, responsible parties, frequencies of activities and target dates for activities completion. QM activities incorporate contractor, stakeholder and recipient input and serve to further the vision of the Division.[1]

The QM Plan includes activities designed to meet federal and Medicaid requirements as well as data driven, focused performance improvement activities conducted by our contractors. This includes all quality improvement activities conducted by BQMO and its contractors, including the monitoring and oversight of contractor QM activities. The Division uses analysis of the behavioral health system's performance, feedback from behavioral health recipients and stakeholders, and evidence based practices to drive the performance improvement activities and new initiatives included in this Plan. Technical assistance is provided to every contractor to ensure compliance with all performance standards and contractual requirements.

The QM Committee ensures ongoing communication and collaboration between Executive Leadership, QM, and other functional areas of the organization, and each functional area is represented on the QM Committee. Members are informed of confidentiality and conflict of interest requirements related to serving on the committee. Sign-in sheets with confidentiality and conflict of interest language are completed at all meetings. The committee reviews, modifies, and updates QM program objectives, policies and procedures at least annually and completes quarterly status reviews of the QM Work Plan.

ADHS/DBHS' QM Committee receives feedback and recommendations for performance improvement activities from various subcommittees, work groups and other functional areas. A QM Coordinators meeting is held quarterly with contractors to disseminate information, provide technical assistance, and receive feedback from the contractors. The Medical Management/Utilization Management (MM/UM) Committee also provides semi-annual updates to ADHS/DBHS' QM Committee on MM/UM activities and makes recommendations to facilitate communication and coordination of improvement activities between QM and MM/UM.

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[1] The complete Quality Management Plan for 2010-2011 is available at http://www.azdhs.gov/bhs/qm/Annual-Quality-Management-Plan_2010-2011.pdf

ADHS/DBHS has also established a Peer Review Committee to improve the quality of medical care provided to behavioral health recipients, and provide oversight and direction to contractors in their peer review activities. The scope of peer review activities includes cases where there is evidence of a quality deficiency in the care or service provided, or the omission of care or a service, by a person or entity that subcontracts with ADHS/DBHS. Cases for peer review may be identified through various monitoring processes, including Quality of Care (QOC) concern reviews and incidents and accidents reports.

BQMO's Office of Performance Improvement (OPI) has general responsibility for ADHS/DBHS' QM functions. OPI is staffed with individuals who have the knowledge, experience, and qualifications to perform QM activities including two members of the Arizona Association for Healthcare Quality (AzAHQ) and one member of the American Society of Quality (ASQ). The Chief of BQMO is a Certified Professional in Healthcare Quality (CPHQ). Furthermore, The Chief of BQMO is supervised by ADHS/DBHS' Chief Medical Officer, who is ultimately responsible for the direction of all QM activities and is accredited by the Utilization Review Accreditation Commission (URAC).

IV: Narrative Plan

G. Consultation With Tribes
Page 43 of the Application Guidance

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

Nationally, Tribal Consultation has its roots dating back to President Bill Clinton's Presidential Executive Memorandum to the Heads of Executive Departments dated April 29, 1994. This landmark Executive Order required all federal agencies directly or indirectly serving American Indians and Alaska Natives to enact Tribal Consultation Policies, and to work with Indian tribes and nations on a government to government basis. Subsequent Presidents have sustained and issued their own Executive Orders recognizing the sovereignty of Indian tribes and requiring adherence to government-to-government relationships with Indian tribes and nations.

In Arizona, Executive Order 2206-14, issued in September, 2006, requires all executive branch agencies reporting to the Governor to enact Tribal Consultation Policies. The underlying purpose of Tribal Consultation is that federal and state agencies will obtain input from Indian tribal elected leaders on all policy issues that impact Indian tribes. The State's Tribal Consultation Policies formally document in detail how state agencies will honor and implement consultation with Indian tribal elected leaders. The Department's Native American Liaison is charged with implementing the Tribal Consultation Policy.[1]

As previously indicated in Section II, Step 2, of this planning application, the priorities, objectives, and strategies identified as areas of strategic focus for the next several years originated in ADHS/DBHS' comprehensive System of Care development process.[2] Creating the System of Care plans involved input from pertinent stakeholders, including Peer and Family members, providers, State sister agencies, and representatives from the various Tribal Regional Behavioral Health Authorities. Furthermore, the Division's cultural competency plan (also detailed in Section II, Step 2) contains several initiatives around improved collaboration with the Tribal Authorities, and working to expand and enhance treatment service availability on the Reservations.

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[1] Executive Order 2006-14 and the Department's Tribal Consultation Policy can be accessed at http://www.azdhs.gov/diro/tribal/consultation.htm
[2] Please see Tables 2 and 3 of this application for priorities and strategies.

IV: Narrative Plan

H. Service Management Strategies
Page 44 of the Application Guidance

Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

ADHS/DBHS currently uses several monitoring methods to determine if Block Grant funds are being used appropriately and effectively, including:

- A quarterly review of RBHA non-Medicaid expenditures for individuals with a substance use disorder. Expenditures are stratified by priority population to determine spending ratios across the groups.
    - This allows ADHS/DBHS to determine whether the RBHAs are appropriately directing funds into the priority groups and outreach / engagement efforts are effective.
- Annual Joint Block Grant Audit conducted by the DBHS Audit and Evaluation Team. RBHAs are reviewed to ensure their internal policies correlate with federal regulations and the providers are monitored for compliance.
- Financial Reporting Requirements – RBHAs must report to DBHS Finance how Block Grant funds are appropriated to their respective service providers, including how the monies will be used to prioritize treatment to the priority populations.
- Review of Provider Audits – RBHAs review their providers' A-133 Circulars for financial compliance of all federal funds – including the Block Grants.
- Annual Independent Peer Review – formerly reported by Goal 15 of the SAPT Block Grant Application. Case review used to ensure SAPT-Funded providers are offering services aligned with recognized best practices.
- On-line waitlist system – Providers must enter the information all priority population members unable to enter residential treatment within the federally-identified timeframes into the ADHS/DBHS waitlist system. Representatives from DBHS and the contracted RBHA are immediately notified by email that a priority population member is in need of, but unable to receive, treatment. The Division and RBHA then begin to coordinate care and seek alternative placement for the member, if necessary.

Moving forward, ADHS/DBHS will also begin conducting service utilization reviews, per person, by service type to identify instances of over utilization. Specifically, on an annual basis, encounter data will be extracted from the ADHS/DBHS Client Information System (CIS) and reviewed to determine the mean cost expended per service type during the reporting year. Once established, clients who received a service value exceeding three standard deviations of the mean, by service, will be identified and their information forwarded to the contracted RBHA for further analysis. The three standard deviation benchmark is universally accepted as an appropriate standard for utilization reviews, as any recipient served beyond that standard will be in the top 99.7% of all individuals utilizing that service.

The RBHAs will be expected to review the case files of these high utilizers and determine if the service level provided was appropriate given their clinical need and in alignment with the individual's service plan. Selected cases may be forwarded to the Department's Office of Program Integrity, in instances where fraudulent activity is suspected, for further investigation.

Under utilization reviews will be conducted in a similar manner; however, these cases will be reviewed to determine if the reduced service amount was due to a lack of necessity, or whether or not the network was sufficiently able to provide the needed services (gap analyses).

Methodology for both reviews is currently being developed and finalized. It is anticipated the first round of these reviews will occur in late calendar year 2011 and conducted annually thereafter.

IV: Narrative Plan

I. State Dashboards (Table 10)
Page 45 of the Application Guidance

Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year: 2012

Priority	Performance Indicator	Selected
Child and Adolescent Enrollment	Number of individuals enrolled in the behavioral health system, under the age of 18, who are diagnosed as having a substance use disorder or dependence.	∈
Older Adult Enrollment	Number of individuals enrolled in the behavioral health system, over the age of 55, who are diagnosed as having a substance use disorder or dependence.	∈
Service Provision to Members of the Military	The number of behavioral health recipients enrolled who indicate being a current or former member of the armed forces. Baseline to be established in Calendar Year 2012; subsequent performance will be expected to exceed that of the prior year.	∈
Peer and Family Involvement	The Statewide number of peer and family members actively participating on behavioral health workgroups, committees, advisory boards, panels, and policy-making bodies.	∈
Peer and Family Support Services	The number of individuals who receive Peer and/or Family support services as part of their treatment regimen.	☒
Health Disparities	Change in client status from intake to update/closure on the National Outcome Measures, analyzed for the total adult substance abusing population, and separately by Race/Ethnicity, Gender, Age Band, and LBGTQ.	∈
Health Integration	Behavioral Health Service providers communicate with and attempts to coordinate care with the Behavioral Health Recipient's acute health plan/PCP	☒
Suicide Prevention	The suicide rate in Arizona is to decrease from 16.1 per 100,000 persons (age adjusted) to 14.0 per 100,000 persons.	∈
Trauma Informed Care	Pre and Post Test survey results to determine provider familiarity with the tenants of Trauma Informed Care and the importance of its integration.	∈
Medically Assisted Therapy	The number of individuals with a substance use disorder or dependence (SUD) who receive Medically Assisted Therapy as part of their treatment regimen.	☒
Substance Abuse Treatment Placement (ASAM)	The percentage of providers' staff members who successfully complete the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC)	∈

Footnotes:

In an effort to increase operational efficiency and effectiveness, support comprehensive strategic planning, promote an unprecedented level of system-wide accountability and transparency, and ensure that scarce public resources are being appropriately utilized in a manner that supports client recovery and resiliency, in January, 2011, ADHS/DBHS officially launched a public behavioral health system Outcomes Framework and Performance Dashboard.

The Framework and Dashboard, available on the Division's web site (http://www.azdhs.gov/bhs/dashboard), is the culmination of a near year-long collaborative endeavor involving pertinent stakeholders, including representatives from each ADHS/DBHS functional area and peer and family members from the community. Additionally, development of the statewide dashboard coincided with that of our regional contractors whom, at the request of ADHS/DBHS, had begun creating their own dashboards that addressed the needs of their unique populations.[1] This was being done in a concerted, statewide, effort to shift the paradigm of system evaluation away from solely relying on process measures, such as access to services, and instead focusing on the benefits individuals within the behavioral health system gain from treatment by assessing their status on multiple "Quality of Life" indicators –such as increased employment and a reduction in criminal activity.

On the direction of ADHS/DBHS leadership, the Outcomes Workgroup was tasked with the development and implementation of a statewide outcomes framework that would:
- Identify and define relevant outcomes and performance indicators, and how each would be measured;
- Adhere to recommended industry standards for system evaluations and transparency;
- Align with the Federal promotion of using dashboards to market agency performance;
- Determine the most effective way to publicly present system outcome performance;
- Serve as a foundation for future strategic planning efforts; and
- Provide a common language to support accurate communication and decision making.

The Workgroup began by defining an "outcome" with respect to the behavioral health system. Unlike physical or acute healthcare, where treatment progress can be more-readily determined, i.e. broken bones can be healed, high blood pressure or other illnesses can be treated through a medication regimen, successful behavioral health treatment is difficult to both qualify and/or quantify. To this extent, the group determined that an outcome would be defined as *the end result of the delivery and receipt of services as measured at a defined point in time.* Furthermore, the group emphasized how outcomes should, and should not, be utilized to assess system performance. Specifically, focusing on outcomes can inform decision makers as to how well a process is functioning and where resources should be allocated; however, outcome reviews alone cannot determine *why* a process is effective or ineffective, or identify root causes.

Because of the inherent limitations of stand-alone outcomes analyses, the workgroup determined that a more comprehensive approach must be taken, particularly one that emphasizes outcomes while recognizing the critical importance of the various system inputs, such as Access to Care,

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[1] Contractor Dashboards are Accessible at:
http://magellanofaz.com/dashboards; (Magellan)
http://www.cenpaticoaz.com/aboutus/performance-measures; (Cenpatico)
http://www.narbha.org/for-providers/provider-profile/fy11-performance-comparison ; (NARBHA)
http://w3.cpsa-rbha.org/static/index.cfm?contentID=2609 (CPSA)

Service Delivery, and Coordination of Care. Together, these factors would be analyzed as a whole and would present a complete, wrap-around, approach to system evaluation.

The group reviewed 'dashboards' implemented by other States, as well as from the private sector – including those from industries other than healthcare – to use as potential models for Arizona's dashboard. Peer and Family involvement was critical in this respect, as these individuals made recommendations as to what indicators should be measured and presented on the dashboard, as well as several design suggestions to ensure the ADHS/DBHS dashboard was user-friendly and easily understood by the viewer; they were also instrumental in developing the verbiage used to describe each indicator.

Lastly, the group recognized that a primary purpose of a dashboard was to promote organizational efficiency and effectiveness. Therefore, from project onset, it was determined that ADHS/DBHS would only utilize data currently collected as part of its daily business operations; contractors would not be asked to gather any new client information to populate the dashboard, as doing so would increase the administrative burden on their staff. Additionally, the new outcomes focused model would require consistency in evaluations between the Adult and Children populations, and a uniform approach to statistical analysis – which would permit ADHS/DBHS to include the status of every enrolled client on the dashboard at the aggregate level, and not rely on a sample subset.

The end result of this workgroup's effort is a robust, uniform, and comprehensive approach to system evaluation, presented in an easy to read dashboard and scorecard format separated in four unique, yet equally important, categories - Outcomes, Access, Service Delivery and Coordination/Collaboration. These categories, and their respective components, were strategically selected due to their unique ability to serve as system performance indicators at each level of the service delivery network, as well as their interdependence and influence on one another.

For example, monitoring the system's ability to provide services in a timely manner at convenient locations **(Access)**, providing individuals an opportunity to participate in their treatment planning **(Service Delivery)**, and interacting with the behavioral health recipient's primary care physician **(Coordination/Collaboration)**, should ultimately result in an improved quality of life for those in the behavioral health system **(Outcomes)**.

The categories include data from a variety of sources - demographic data provided by clients on a regular basis, individual and family survey data, analysis of claims data, audits of client records and data reported by the RBHAs. The Framework organizes the data by these categories and presents the information in easy to read, as presented below:

	Statewide
Outcomes: Individuals . . .	Has quality of life improved for individuals served by the behavioral health system?
With a drug/alcohol use history are now abstaining	30.8%
Are not homeless	97.5%
Are employed	14.2%
Attend school	36.4%
Have no recent criminal justice system involvement	93.7%
Participate in self-help groups	**Coming in 2012**

	Statewide
Access: Individuals . . .	Do individuals and families have access to recovery and resiliency oriented services?
Are satisfied with their access to services	81.8%
Receive timely services	89.2%
Live within 15 miles of an outpatient clinic	98.4%

	Statewide
Service Delivery: Individuals . . .	Are services provided based on the needs of individuals and families?
Participate in their treatment planning	91.6%
Have current and complete service plans	40.2%
Receive services identified on their service plan	**Coming in 2011**

	Statewide
Coordination/Collaboration: Individuals . . .	Do individuals and families get seamless behavioral and medical care coordination?
Have their care coordinated with their medical doctor	88.0%
Return to a psychiatric hospital	18.3%
Stay in a psychiatric hospital an average of . . .	10.9 days

The viewer also has the option of comparing performance in all the above metrics between the Adult and Child populations, as well as among the various system contractors based on their Geographic Service Area (GSA); for example:

	Statewide Adult	Statewide Child
Access: Individuals . . .	Do individuals and families have access to recovery and resliency oriented services?	
Are satisfied with their access to services	80.8%	83.0%
Receive timely services	91.7%	86.0%
Live within 15 miles of an outpatient clinic	98.5%	98.3%

	GSA 1 NARBHA	GSA 2 CBHS	GSA 3 CPSA/CBHS	GSA 4 CBHS	GSA 5 CPSA	GSA 6 Magellan
Coordination/Collaboration: Individuals . . .	Do individuals and families get seamless behavioral and medical care coordination?					
Have their care coordinated with their medical doctor	85.9%	94.7%	88.1%	87.7%	91.8%	81.9%
Return to a psychiatric hospital	11.7%	3.6%	17.5%	13.9%	14.3%	19.4%
Stay in a psychiatric hospital an average of. . . days	9.9	35.5	6.0	9.9	5.4	10.9

From conception, the Outcomes Framework and Dashboard initiative was designed to incorporate client and program level data that was being submitted to ADHS/DBHS as part of our standard business practices. Therefore, start-up costs for the Outcomes Framework and Dashboard were minimal and limited only to staff time. Furthermore, the new dashboard system has replaced several ad-hoc informational reports that had been created in the past, which has led to time and resource savings for ADHS/DBHS staff. It is also ADHS/DBHS expectation that the dashboard will greatly reduce administrative burden on staff tasked with fulfilling information requests from various stakeholders, including other State agencies, governing bodies, and the general public – as these groups can now be referred to the online dashboard. Lastly, the Outcomes Framework and Dashboard has been fully integrated into ADHS/DBHS routine operations and is maintained by staff as part of their daily responsibilities. There is no specific line-item funding required for this initiative.

Community reaction to the ADHS/DBHS dashboard, as well as those of our contractors, has been positive, with many commenting that the increased focus of system accountability and transparency will naturally drive performance improvement. Internally at ADHS/DBHS, the Framework and Dashboard are providing invaluable direction as to where future performance improvement initiatives are needed.

Meanwhile, among our regional contractors, some provider organizations were initially reluctant to have their performance data made public; however, the regional contractors addressed these concerns by involving the providers in each phase of the dashboard development process. Together, all parties were able to come to a consensus on what elements would be included in their respective dashboards,

and how each would be defined and measured. Furthermore, once these dashboards went 'live', an unexpected competitive –yet civil -atmosphere began to develop amongst the provider organizations and, as a result, they began to look internally at their own processes to find ways they may improve their performance on the dashboard measures. Regional contractors report lively discussions during monthly provider meetings whereby the organizations share details on changes they have made and the subsequent performance improvements they are seeing as a result.

Future Enhancements
The statewide ADHS/DBHS Outcomes Framework and Dashboard was officially 'launched' in January, 2011; while there are plans for eventual expansion, the Division recognizes the importance of maintaining the dashboard in its original design to allow for year-over-year performance comparisons across the various populations and Geographic Service Areas of the treatment network.

Though this program is still in its very early stages, ADHS/DBHS staff has already identified numerous enhancements that can be made to the dashboard, some of which will be noticeable to the viewing public, while others involve upgrades to our underlying data architecture needed to streamline reporting processes and reduce staff involvement in maintaining and updating the dashboard.

To begin, ADHS/DBHS is seeking to acquire a Business Intelligence (BI) software platform that will interface seamlessly with our existing data system. When programmed, it is our expectation that the BI platform will be capable of extracting client information, performing the required calculations and statistical analyses, and updating the online dashboard on pre-determined intervals. Presently, data extraction, analysis, formatting, and reporting are done manually by ADHS/DBHS staff; an automated BI would allow these employees to focus on addressing identified areas of underperformance and developing policies to drive system improvement.

Furthermore, ADHS/DBHS will be expanding the Dashboard to display basic client demographic information on the statewide aggregate level, i.e., gender, race, ethnicity, and age distribution profiles of the individuals served within the behavioral health system. It is our anticipation that this information would be updated on at least a quarterly basis to provide an accurate overview of the treatment community which, in return, will identify population subsets that may be underserved and in need of an enhanced level of outreach and engagement.

Additionally, the dashboard will be further expanded to delineate, and display, system performance among the separate adult behavioral health categories (Seriously Mentally Ill, General Mental Health, and Substance Abuse) – as well as separate these sub-populations by Medicaid eligibility. Doing so will present a more detailed analysis of how the individual client groups are impacted by the behavioral health system and allow the Division to develop population-specific action plans to address areas of concern.

It is anticipated that the formatting changes to the dashboard will be implemented in late calendar year 2011; however, acquiring the Business Intelligence software platform will be dependent on resource availability. At present ADHS/DBHS is developing a Scope of Work necessary to begin the procurement process and solicit bids from potential BI partners.

IV: Narrative Plan

J. Suicide Prevention
Page 46 of the Application Guidance

Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

The Arizona Suicide Prevention Plan, developed by a consortium of State agencies, is based on the goals of the U.S. Surgeon General's National Strategy for Suicide Prevention: Goals and Objectives for Action (2001), with objectives and additional recommendations modified for Arizona. Priority areas from the ADHS planning committee process for implementation in Arizona are noted in bold.

Goal 1: Promote Awareness that Suicide is a Public Health Problem that is Preventable
- *Objective 1:* Develop a public education campaign.
- Increase education and awareness of the scope of the suicide problem in Arizona and promote cooperation and collaboration with the general public to address the problem.
- *Objective 2:* Sponsoring a state conference and participate in national conferences on suicide and suicide prevention.
- *Objective 3:* Organize special-issue forums.
- *Objective 4:* Disseminate information through the internet.

Goal 2: Develop Broad-Based Support for Suicide Prevention
- *Objective 1:* Organize a statewide interagency committee to improve coordination and to ensure implementation of the National Strategy and Arizona Priorities Plan.
- *Objective 2:* Establish public/private partnerships dedicated to implementing the National Strategy and the Arizona Priorities for Suicide Prevention Plan.
  - Develop and strengthen collaborative relationships (schools, employers, clergy, legislators, government, etc.) to promote necessary policy change and expand funding and other community resources for suicide prevention.
- *Objective 3:* Increase the number of professional, volunteer and other groups that integrate suicide prevention activities into their ongoing activities.
- *Objective 4:* Increase the number of faith communities that adopt policies designed to prevent suicide.

Goal 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse and Suicide Prevention Services
- *Objective 1:* Increase the number of suicidal persons with underlying mental disorders who receive appropriate mental health treatment.
  - Increase the number of persons who receive mental health and substance abuse treatment by reducing barriers to care for people who are at risk. Ensure immediate linkage to treatment for individuals who attempt suicide. Develop treatment planning guidelines and procedures for attempters and their peers/family members.
- *Objective 2:* Transform public attitudes to view mental health and substance abuse use disorders as real illness, equal to physical illness, that respond to specific treatments and to view persons who obtain treatment as pursuing basic health care.
  - Create opportunities to educate and reduce stigma around mental health, substance abuse, and suicidal behavior and seeking help for problems.

Goal 4: Develop and Implement Community-Based Suicide Prevention Programs
- *Objective 1:* Increase the proportion of counties and communities with comprehensive suicide prevention plans.
- *Objective 2:* Increase the number of evidence-based suicide prevention programs in schools, colleges and universities, work sites, correctional institutions, aging programs, and family youth and community service programs.

o Work with communities, using a risk and protective factor framework, to increase the number of evidence-based suicide prevention programs addressing general and targeted populations within Arizona's communities.

- *Objective 3:* Develop technical support centers to build capacity across the State to implement and evaluate suicide prevention programs.
  - o Develop a technical support center for training para professionals and gatekeepers in suicide risk assessment, crisis intervention and addressing the needs of attempters and survivors.

Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm

- *Objective 1:* Educate health care providers and health and safety officials on the assessment of lethal means in the home and actions to reduce suicide risk.
- *Objective 2:* Implement a public information campaign designed to reduce accessibility to lethal means.
  - o Design one or more community-level education campaigns targeting accessibility to lethal means.
- *Objective 3:* Improve firearm safety and establish safer methods for dispensing potentially lethal quantities of medications and seeking methods for reducing carbon monoxide poisoning from automobile exhaust systems.
- *Objective 4:* Supporting the discovery of new technologies to prevent suicide.

Goal 6: Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment

- *Objective 1:* Improve education for nurses, physician assistants, physicians, social workers, psychologists and other counselors.
  - o Develop professional education and training for healthcare, law enforcement, emergency medical services, fire, and emergency response teams on effective intervention and management of depression and other mental health and substance use disorders. Provide physician and medical professional training in undiagnosed depression, mental health, substance use disorders, and suicide risk and responding to suicide attempters, including an understanding of psychosocial development over the life span and its relationship to the suicide attempt.
- *Objective 2:* Provide training for clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide.
  - o Design training for key community gatekeepers on identifying and responding to depression and other mental health and substance abuse disorders within their target populations, including management of suicide attempters and assessing risk in grieving family members.
- Objective 3: Provide educational programs for family members of persons at elevated risk.
  - o Support family members of persons at elevated risk through community education addressing recognition of risk behaviors, undiagnosed depression and other mental health and substance abuse disorders.

Goal 7: Develop and Promote Effective Clinical and Professional Practices

- *Objective 1:* Change procedures and/or policies in target settings, including hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, and other institutions, to improve assessment of suicide risk.

- o Implement training in effective risk assessment and evidence-based treatment to improve identification and management of patients at risk and to improve the overall quality of mental health and substance abuse services. Develop protocols for monitoring current clients during key transitions, including changes in medication use, follow-up on discharge from hospital settings and observation during periods of family stress. Design incentives for providers to deliver evidence-based models of treatment, including culturally appropriate programming.
- *Objective 2:* Incorporate Suicide Risk Screening in Primary Care.
  - o Increase the proportion of physicians that conduct depression, substance abuse and suicide risk screening during routine primary care.
- *Objective 3:* Ensure that individuals who typically provide services to suicide survivors have been trained to understand and respond appropriately to their unique needs (e.g., emergency medical technicians, firefighters, police, funeral directors).
  - o Develop statewide medical guidelines and practice protocols for managing suicide attempts, including responding to survivors, peers and family members in the hours and days immediately following a suicide event.
- *Objective 4:* Increase the number of persons with mood disorders who receive and maintain treatment.
- *Objective 5:* Ensure that persons treated for trauma, sexual assault, or physical abuse in emergency departments, receive mental health services.
- *Objective 6:* Foster the education of family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide.
- *Objective 7:* Develop and/or enhance existing crisis response systems.
  - o Enhance coordination and data-sharing across multiple crisis systems in order to improve response times and the appropriateness of emergency interventions. Improve consistency between federal, state and local policy on responding to suicide events, with a particular focus on reducing criminalization and stigma associated with court-ordered evaluation and treatment. Develop mechanisms for routine meetings and coordination between local first responder networks, including emergency medical services, fire and police, tribal agencies and ADHS contractors (e.g., Regional Behavioral Health Authorities and County Public Health Departments) to ensure locally coordinated suicide crisis response planning.

Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services
- *Objective 1:* Require health insurance plans to cover mental health and substance abuse care on a par with coverage for physical health care.
  - o Increase availability of mental health and substance abuse coverage and funding through parity initiatives. Reimburse innovative treatments with proven effectiveness, including formularies.
- *Objective 2:* Implement utilization management guidelines for suicidal risk in managed care and insurance plans.
  - o Enhance quality and utilization management guidelines to specifically address suicidal risk in managed care and insurance plans.
- *Objective 3:* Integrate behavioral health and suicide prevention into health and social services outreach programs for at-risk populations.

- o Increase understanding and recognition of cultural beliefs that hinder access to care and design outreach programs to reduce suicide contagion through culturally appropriate programming.
- *Objective 4:* Define and implement screening guidelines for schools, colleges, and correctional institutions, along with guidelines on linkages with service providers.
  - o Develop clinically appropriate screening and assessment tools and referral protocols for community institutions to ensure routine access to primary and specialized health care. Ensure continuity during transitions between institutions and the community, including special support service referrals.
- *Objective 5:* Implement support programs for persons who have survived the suicide of someone close.
  - o Expand the base of specialized community services available for suicide survivors and other grieving peers and family members.

Goal 9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media
- *Objective 1:* Establish a public/private group designed to promote the responsible representation of suicidal behaviors and mental illness in the media.
  - o Establish media guidelines for portrayal of suicidal behavior, including a media event team to promote responsible representation of suicide.
- *Objective 2:* Increase the number of news reports that observe recommended guidelines in the depiction of suicide and mental illness.
- *Objective 3:* Increase the number of journalism schools that adequately address reporting of mental illness and suicide in their curricula.

Goal 10: Promote and Support Research on Suicide and Suicide Prevention
- *Objective 1:* Develop a statewide suicide research agenda.
  - o Perform a literature review to identify evidence-based prevention and intervention models. Conduct a cross-agency review of programs in Arizona. Identify federal initiatives in Arizona addressing clinical trials of medication effectiveness, culturally appropriate models, genetics and biological research and other preventive interventions.
- *Objective 2:* Increase funds for suicide prevention research.
- *Objective 3:* Evaluating preventive interventions.
  - o Assess the level and rigor of evaluation in existing prevention and intervention programs. Develop mechanisms for promoting research to practice.
- *Objective 4:* Establish a registry of interventions with demonstrated effectiveness for prevention of suicide or suicidal behavior.
  - o Develop a public access registry of effective models. Design a statewide training, continuing education and certification system for practitioners.

Goal 11: Improve and Expand Surveillance Systems
- *Objective 1:* Develop and implement standardized protocols for death scene investigations.
  - o Improve data collection through the development of standardized protocols for investigating unsuccessful and completed attempts.
- *Objective 2:* Increase the number of follow-back studies of suicide.
- *Objective 3:* Increase the number of hospitals that code for external cause of injuries.

- *Objective 4:* Increase the number of nationally representative surveys with questions on suicidal behavior.
  - Collect and analyze data from survey instruments with items related to suicide, such as the Youth Risk Behavior Survey.
- *Objective 5:* Implement a violent death reporting system that includes suicide.
  - Create standard codes, terminology and protocols in death registries and increase the number of hospitals that code for external cause of injuries.
- *Objective 6:* Produce an annual report on suicide.
  - Review data, identify gaps in services and supports and improve Management Information Systems through the development of appropriate methods to track suicide attempts and completions. Publish an annual report including current suicide surveillance data and epidemiologic analysis.
- *Objective 7:* Support pilot projects to link and analyze information on self-destructive behavior from various, distinct data systems.
  - Profile at-risk persons and /populations, including American Indians, Hispanic/Latinos, the elderly, adolescents, gay/lesbian/bi-sexual persons, females and residents of rural communities. Utilize data to trend suicide events across multiple first response and reporting systems. Develop data matching protocols for linking data in multiple state, county and local databases, including hospital discharges, emergency rooms, behavioral health providers, health plans, and other service agencies

IV: Narrative Plan

K. Technical Assistance Needs
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Narrative Question:
Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

The State plan outlined in this application has been designed largely to conform with the resources and expertise currently available to ADHS/DBHS, our contractors, and direct service providers; however, there are still some areas in which technical assistance provided by SAMHSA would be greatly appreciated, specifically:

- Establishing a comprehensive, and cost effective, needs assessment process based on both quantitative and qualitative data feeds that can be utilized on a recurring basis to determine the true need for mental health and substance abuse prevention and treatment services across Arizona's diverse population subsets;
- How to most efficiently and effectively monitor utilization of selected services at the recipient level, given the structure of Arizona's behavioral health system;
- How to increase the prevalence of recipient-driven service planning while also moving towards a service delivery system that holds providers more accountable for achieving positive changes in numerous outcome measures;
- Integrating behavioral health service utilization data with that of the acute care system to successfully develop and maintain a responsive disease management program, and;
- Improving Coordination of Care between the Acute and Behavioral Health systems in cases where a recipient with a substance use disorder refuses to permit providers to contact their primary care physician – especially in cases involving the prescribing of various medications that may adversely affect the individual if taken in concert with those medications prescribed by a PCP.

ADHS/DBHS has made, or is attempting to make, progress in several of the above areas identified. Reviews of service encounter data, designed to determine over and under utilization, are conducted on a recurring basis; however, given the allowed reporting window for submitting encounter claims, it is difficult to accurately identify instances of high utilization in a timely manner and act appropriately given the circumstances.

Additionally, ADHS/DBHS has begun to hold high-level meetings with the Arizona Health Care Cost Containment System (AHCCCS), the State's Medicaid Authority, to determine the needs of both agencies as it relates to implementing bi-directional information sharing across the behavioral health and acute care systems – this is critical given the State's adoption of the Health Homes initiative for adults with a serious mental illness and physical health needs.

IV: Narrative Plan

L. Involvement of Individuals and Families
Page 46 of the Application Guidance

Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

Peers and family members play a major role in policy development, system transformation, and program implementation at all levels of the service delivery network, and the Division, RBHAs, and providers work with the various coalition groups throughout the State to encourage their involvement and engage in relationship building. Most notably, in fiscal year 2011, Peer and Family members were instrumental in their involvement with numerous *priority work groups* tasked with addressing significant budget reductions to the behavioral health system, and determining how the system would recalibrate and provide needed services given the reduced funding for non-Medicaid eligible individuals. These work groups developed plans for housing, crisis services and the transitioning of non-Medicaid SMIs to medication-only services and community supports.

Under the direction of the Chief Medical Officer and Deputy Director, ADHS/DBHS has published several clinical practice protocols, based on best practices, to assist behavioral health providers in increasing the use of peer and family involvement. The Clinical and Recovery Practice Protocol, "*Peer Workers/Recovery Support Specialists within Behavioral Health Agencies*" was developed to provide guidance to behavioral health agencies in implementing peer worker/recovery support services within their organizations, and to enhance the effectiveness of mental health and substance use disorder services through the expansion of peer-delivered services. Likewise, a *Family & Youth Involvement in the Children's Behavioral Health System of Care* clinical and practice protocol does the same for family and youth/young adult employee and volunteer roles in the Children's system.

In Arizona, the minimum staffing requirement for peer-delivered services within licensed behavioral health agencies is the behavioral health paraprofessional. Peer workers that meet the requirements for this paraprofessional role may work in any position for which they are qualified within the organization. In addition, peer employees hired by a certified Community Service Agency (CSA) must also meet minimum staffing requirements for paraprofessionals within licensed behavioral health agencies, as defined in Arizona Administrative Code to deliver supportive services identified on a treatment plan.

The ADHS/DBHS Office of Individual and Family Affairs (OIFA) was created in 2006 to advance empowerment of individuals, family members and youth in the recovery process and to ensure that their voice is heard and included in all major decisions pertaining to Arizona's behavioral health systems of care. OIFA ensures that individuals, family members and youth are equal partners at all levels in initiating and sustaining improvements in Arizona's behavioral health system, and provides information, education and support for children, youth, families, adults and older adults who are challenged by mental illness or substance use. Peers and family members now actively participate on committees and other initiatives including the Adult and Children's System of Care development, Systems Transformation, Stigma Reduction, Trauma-Informed Care, and Health Care Integration.

In addition, each RBHA has established an Individual and Family Affairs Unit (IFA) to further ensure that behavioral health recipients are involved in all levels of the system. The RBHA IFAs' mission is to educate members and their families to better advocate for needed services; to recruit a diverse group of members, youth and family members to participate in decision making at the RBHA and provider levels; and to ensure that their participation is meaningful and has impact on the decisions made. This is accomplished by building partnerships with individuals, families and youth to promote recovery, resiliency and wellness. It is important to increase the individual and family voice in areas of leadership and service delivery. Additional important tasks are to partner with individuals and families to identify and remove barriers to service and educate the behavioral health workforce on the practices and benefits of peer/family involvement in service planning, service delivery and system transformation.

OIFA and the IFAs work closely with *peer/family run organizations* throughout Arizona to develop strategies and collaborate on recovery/wrap-around projects, including transition age youth and family and peer involvement in the behavioral health system. ADHS/DBHS contracts with some peer and family run organizations for specific projects, such as NAMI Arizona, Recovery Innovations of Arizona and the Family Involvement Center.

The Arizona Peer and Family Coalition, created in 2010, is comprised of peers and family members who advocate for full inclusion and participation in the decision-making processes at the State level. Members of the Coalition have teamed with OIFA to travel around the state and introduce the Coalition to rural communities. These trips to places such as Payson, Flagstaff, Sierra Vista and Yuma have been well received, because the participants see the ADHS/DBHS and the Coalition as being proactive in hearing what successes and shortcomings people experience in these rural and remote areas.

Does the State sponsor meetings that specifically identify individual and family members' issues and needs?
In addition to the budget crisis, a long-standing class action lawsuit, *Arnold vs. Sarn*, is currently "on stay" through June 2012. During this time, the parties have been instructed to develop new criteria for assessing system performance and monitoring compliance. In response, the Division is making many needed improvements to the system to better serve adults with serious mental illness. The Division has sought community input to help design a transformation strategy based on a set of court-ordered requirements that the parties agreed to when the lawsuit was placed "on stay".

The first and most important step was to include peers and family members in the process of evaluating and developing improvements to the system, and ascertain what services peers and family members felt were needed from the behavioral system. ADHS/DBHS began its work in FY 2011 by forming a DBHS *System Transformation Work Group* in which peers and family members are actively involved. Working from existing court orders and related documents, the Workgroup developed a list of questions to gather peer and family member opinion.

In collaboration with peers/families, the *Raise Your Voice Project* was created utilizing the Community Based Participatory Research (CBPR) – a recognized evidenced-based practice. Peers and family members were trained and facilitated 26 statewide peer and family focus groups where 370 participants decided what recovery meant to them; what services were most important; when, where and how they wanted services to be delivered; and how they expected behavioral health staff to respond to their needs. This qualitative data was then entered, verbatim, by peers and family members and then categorized and trended with SPSS Text Analysis software. Analysis of the data revealed eight consistent themes for Arizona's behavioral health system: individualized care, supportive services, peer support services, community-based resources, living arrangements, transportation, crisis services and integrated health services. The Workgroup compiled a written and statistical report on the findings of this project which has been made available statewide in July 2011.[1] ADHS/DBHS will use the information and recommendations from the *Raise Your Voice Project* to make improvements, wherever possible.

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[1] The full report can be viewed on the Division's website at http://www.azdhs.gov/bhs/transform.htm.

Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?:

The Arizona Stigma Reduction Committee conducts statewide Arizona Dialogues (patterned after SAMHSAs participatory dialogues). The Arizona Dialogues are conducted by trained Co-Facilitators and have been very successful in engaging groups in deep discussion and exploration of a variety of aspects of community inclusion and stigma. The goal of Arizona Dialogues is to raise awareness and affect positive changes in attitude and behavior toward persons with mental illness/substance use disorders and their families. Additionally, the Committee has developed presentations, which include experience sharing, to raise awareness of the negative effects of stigma and positive benefits of inclusion. The Committee conducts these programs all over the state and also has a presence at many health/wellness fairs and is an exhibitor at local conferences. In fiscal year 2011, the Committee developed and implemented a plan to establish 6 Regional Stigma Reduction Committees (RSRC); this activity will continue into FY12 with the first RSRC already established in Pima County.

Because the Arizona Dialogues have been so successful, the Trauma-Informed Care Taskforce embarked on promoting the Trauma Informed Care (TIC) philosophy to the public behavioral health system through a Dialogue/Focus Group combination. The goal of this project is to develop a statewide TIC needs assessment, and to spread awareness concerning trauma informed care, particularly around sanctuary trauma. TIC Dialogues offer an avenue in which peer and family members become active participants in systems transformation by sharing their experiences and speaking about their needs and those of the community related to trauma. Twenty-three TIC Dialogues are being conducted throughout the State, with the findings to be submitted to DBHS for a needs assessment analysis in September 2011. TIC Taskforce and DBHS will plan future activities based on the results of the needs assessment report.

The *Arizona Peer & Family Coalition* is collaborating with the Office of Individual and Family Affairs to develop an orientation for volunteer peers and family members that will cover learning about the structure of our behavioral health system, how it is funded, its covered services through the T/RBHAs, how the funding flows, along with how to be an effective committee, council or board member. Upon successful completion of the orientation, peers and family members will be placed on internal decision-making ADHS/DBHS and T/RBHA committees, councils, and boards.

OIFA promotes trainings and conferences that are offered throughout the state for cultural competence, recovery, advocacy, stigma reduction, etc. for peers and family members as well as behavioral health professionals on a weekly basis through its list serve, on its Arizona Happenings Events online calendar and in the DBHS Recovery Works newsletter. OIFA also hosts national webinars and invites community members and behavioral health workers to join us for viewing the webinar and discussion afterwards.

How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system:

Methods described above are utilized to engage and inform individuals and their family members about peer and family involvement, peer and family driven care, self-determination, constructive advocacy, peer/parent and professional partnerships. Peer and family-run organizations provide workshops and groups to address treatment and service planning, recovery, self-advocacy, goal setting, etc.

Furthermore, an ADHS/DBHS Director routinely holds a statewide informal 2-hour Brown Bag (lunch) session in which peer and family community members are invited to attend and discuss current and future system initiatives. Teleconference and Telemed make it possible for those in outlying areas to participate in these sessions.

How does the State support and strengthen and expand recovery organizations, family peer advocacy, self help programs, support networks, and recovery oriented services:
As noted in a previous section, each RBHA has established an Individual and Family Affairs Department to collaborate with members and their families to better advocate for needed services; to recruit a diverse group of members, youth and family members to participate in decision making at the RBHA and provider levels; and to ensure that their participation is meaningful and has impact on the decisions made.

The RBHAs have consistently provided training and support to adult peer and family mentors across the state. Magellan's Recovery and Resiliency team initiated the start up of the Clinic Advisory Councils at each clinic in its system to serve as a place where the clinical staff, service recipients, administration, family members and community members can come together monthly to discuss and make decisions as to what is working and where improvements can be made. The Clinic Advisory Councils were developed to ensure the voice of the consumer was heard.

In fiscal year 2011 ADHS/DBHS developed Guiding Principles for the adult behavioral health system, which are designed to provide a shared understanding of the key ingredients needed for an adult behavioral health system to promote recovery. System development efforts, programs, service provision, and stakeholder collaboration are guided by these principles. The principles are also used to guide the State's decision making process and interactions.

The Guiding Principles were influenced by the SAMHSA Consensus Statement, the U.S. Psychiatric Rehabilitation Association Core Principles, ADHS/DBHS Vision Statement, Arizona's Five Principles for Person Centered Treatment Planning, and Arizona's 12 Principles for Children's Behavioral Health Care. Peer run agencies and RBHAs in all regions of the state held focus groups with peers to dialogue around the needed ingredients for a recovery oriented system and to seek input in the development of the Principles. The Statewide Family Committee also provided feedback and input. A particular emphasis was placed on ensuring that the Principles correlated with and complemented the 12 Principles for Children's Behavioral Health Care. The Arizona Behavioral Health Planning Council and its Community Advisory Committee took the lead in gathering all input; the Committee hosted additional input and discussion sessions over the course of a year, opening the sessions up to all individuals and family members from around the state.

The following Nine Guiding Principles and narratives were crafted and agreed upon as the foundation of Arizona's adult behavioral health system:
1. Respect
2. Persons in recovery choose services and are included in program decisions and program development efforts
3. Focus on individual as a whole person, while including and/or developing natural supports
4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure
5. Integration, collaboration, and participation with the community of one's choice

6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust
7. Persons in recovery define their own success
8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences
9. Hope is the foundation for the journey towards recovery

IV: Narrative Plan

M. Use of Technology
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<u>Narrative Question:</u>

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

The implementation and adoption of new technologies designed to benefit recipients of behavioral health services, and enhance the effectiveness of the treatment network, has been limited to the use of telemedicine and videoconferencing – primarily in the more rural areas of the State. These tools have been instrumental in connecting the Division's Administration with their counterparts at the T/RBHAs serving rural Arizona, and allowing for statewide participation in numerous committees – making travel unnecessary in many situations. Telemedicine is also used to connect providers with behavioral health recipients in instances where a doctor or therapist is not immediately available in the local area, or in cases where it is more convenient for either party and will not adversely impact the therapeutic relationship.

The Division is currently exploring new technologies and determining which ones could be effectively adopted across the network, enhancing service provision to our recipients, while also providing the greatest marginal benefit, as a ratio to the costs associated with implementation, to our contractors. Specifically being considered is the adoption of a software platform that will utilize text messaging to improve retention in treatment for clients leaving an inpatient detoxification setting, a residential treatment setting, or an intensive outpatient treatment program, and transitioning into standard outpatient services. Participating clients would receive appointment reminders and recovery tips via cell phone test message. A survey recently conducted by CPSA around this technology found that a substantial number of young adults (18-30 years) would be interested in receiving communications in this manner and believe it would benefit their treatment.

The initial research of this technology's use has indicated positive benefits to the recipients and a reduction in appointment no-show rates. Additionally, implementation costs appear nominal and typically include a monthly subscription fee with a charge for each message sent. Many packages will reduce, or waive, the monthly fee if the volume of text-messages sent exceeds a certain amount. Consideration of this, and other, technologies is ongoing and implementation will be dependent on available funds.

Furthermore, the RBHAs are making great strides in adopting new technologies supportive of treatment for those in the behavioral health system. Specifically, Cenpatico's Health Passport System, a web-based application, allows providers to improve care coordination, eliminate waste, and reduce errors by gaining a better understanding of a person's medical history and health interactions. This system promotes the sharing of clinical information between providers, state agencies, and various facilities.

IV: Narrative Plan

N. Support of State Partners
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Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

ADHS/DBHS partners with other State agencies, including the Department of Economic Security, Juvenile and Adult Corrections, Department of Education, the Administrative Office of the Courts, the Governor's Office, and the Arizona Health Care Cost Containment System (Medicaid), to provide a comprehensive array of publicly funded services to children and adults through memoranda of understanding, intergovernmental service agreements or informal relationships. Formal partnerships include:

- Intergovernmental Agreement between ADHS/DBHS and the Department of Economic Security, Rehabilitation Services Administration (DES/RSA): An agreement exists between these two state agencies in order to increase coordination and facilitate the expansion of vocational rehabilitation services.
- Intergovernmental Agreement between ADHS/DBHS and Pima County Board of Supervisors: This agreements states that ADHS/DBHS shall provide a comprehensive, community-based system of mental health care for persons residing in Pima County with serious mental illness.
- Interagency Services Agreement between ADHS/DBHS and the Department of Economic Security, Division of Developmental Disabilities (DES/DDD): The two agencies collaborated to finalize a Practice Improvement Protocol for "Pervasive Developmental Disorders and Developmental Disabilities". ADHS/DBHS provides training and technical assistance to the T/RBHAs around the protocol as needed or requested.
- Interagency Services Agreement between ADHS/DBHS and the Arizona Department of Housing (ADOH): This agreement was developed with the purpose of outlining duties to be performed by ADOH to provide technical assistance, project underwriting, and risk assessment analysis, as well as making final recommendations to ADHS/DBHS on the feasibility of funding particular housing projects for persons with serious mental illness.
- Intergovernmental Agreement between ADHS/DBHS and Maricopa County Board of Supervisors
- The Arizona Substance Abuse Partnership (ASAP): The Arizona Substance Abuse Partnership serves as the single statewide council on substance abuse issues. ASAP brings together stakeholders at the federal, state, tribal and local levels to improve coordination across state agencies; address identified gaps in prevention, treatment and enforcement efforts, and; improve fund allocation. ASAP utilizes data and practical expertise to develop effective methods for integrating and expanding services across Arizona, maximizing available resources. ASAP also studies current policy and recommends relevant legislation for the Arizona Legislature's consideration.
- Arizona Suicide Prevention Coalition: T/RBHAs, contracted providers, and the Department of Health Services are all active participants in the Arizona Suicide Prevention Coalition. This group conducts research and gathers data, creates publicity and works to make policy changes. Areas of focus include the media, Native Americans, older adults, and youth.
- Arizona Children's Executive Committee (ACEC): ACEC brings together multiple state and government agencies, community advocacy organizations, and family members of children/youth with behavioral health needs to collectively ensure that behavioral health services are being provided to children and families according to the Arizona Vision and 12 Principles. ACEC strives to create and implement a successful system of behavioral health care in Arizona by serving as a state-level link for local, county, tribal and regional teams.

Representatives from many of these organizations are members of, and actively participate on, the Arizona Behavioral Health Planning Council.[1] The Council is tasked with the following responsibilities:

- Reviewing plans and submitting to the State any recommendations for modification.
- Serving as an advocate for adults with a serious mental illness and children who are seriously emotionally disturbed, including individuals with mental illnesses or emotional problems.
- Monitoring, reviewing, and evaluating, not less than once per year, the allocation and adequacy of mental health services in the State.
- Participating in improving mental health services within the State.

Per the new guidelines of the National Block Grant requirements, and in response to the recommendations of the Substance Abuse and Mental Health Services Administration (SAMHSA), Arizona's Behavioral Health Planning Council will move to incorporate more substance abuse prevention and treatment subject matter expertise in fiscal year 2012.

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[1] Please see Application Section 'O' (Tables 11 and 12) for Planning Council membership details.

IV: Narrative Plan

O. State Behavioral Health Advisory Council
Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

The Arizona Behavioral Health Planning Council has reviewed this planning application per Public Law 103-321. Please see application attachments for their formal statement of review.

IV: Narrative Plan

Table 11 List of Advisory Council Members
Page 51 of the Application Guidance

Start Year: [   ]

End Year: [   ]

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Candice Trainor	State Employees	Education	1535 W. Jefferson St Phoenix, AZ 85007	
Letitia Labrecque	State Employees	Social Services	1789 W Jefferson, 930A Phoenix, AZ 85007	llabrecque@azdes.gov
Dr. Kimberly Linder	State Employees	Criminal Justice	1601 W. Jefferson Phoenix, AZ 85007	
Karia Basta	State Employees	Housing	1100 W. Washington, Ste. 310 Phoenix, AZ 85007	
Mark Ewy	State Employees	Social Services	1789 W Jefferson, 930A Phoenix, AZ 85007	mewy@azdes.gov
Kristin Frounfelker	State Employees	Medicaid	701 E. Jefferson Phoenix, AZ 85007	
Dr. Laura Nelson	State Employees	Arizona Department of Health Services	150 N. 18th Ave, Ste. 500 Phoenix, AZ 85007	
Vicki Johnson	Providers	MIKID	2648 E. Thomas Rd. Phoenix, AZ 85016	vickij@mikid.org

Jennifer Alewelt	Others (Not State employees or providers)	Arizona Center for Disability Law	5025 E. Washington St, Ste. 202 Phoenix, AZ 85034	
Steve Carter	Providers	NOVA, Inc	4425 W. Olive Ave., Ste. 200 Phoenix, AZ 85007	scarter144@aol.com
Lyle Ford	Individuals in Recovery (from Mental Illness and Addictions)	SEACRS	PO Box 2648 Sierra Vista, AZ 85635	lylef@seacrs.org
Ann Froio	State Employees	Mental Health	150 N. 18th Ave Phoenix, AZ 85007	ann.froio@azdhs.gov
Janet Fuhriman	Providers	Arizona's Children Association	PO Box 7727 Tucson, AZ 85725-7277	
Phyllis Grant	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	MIKID	4500 E. Speedway, Ste. 58 Tucson, AZ 85712	phyllisg@mikid.org
James Russo	Individuals in Recovery (from Mental Illness and Addictions)	Phoenix Visions of Hope	601 W. Hatcher Rd. Phoenix, AZ 85016	jmrusso@phxhope.org
Tonya Aleisawi	Individuals in Recovery (from Mental Illness and Addictions)		11481 West Rock Village Road Marana, AZ 85658	tonya.aleisawi@cpsa-rbha.org
John Baird	Individuals in Recovery (from Mental Illness and Addictions)		1036 3rd Avenue San Manuel, AZ 85651	jonbaird1@hotmail.com
Julia Engram	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		12841 West Aster Drive El Mirage, AZ 85335	juliaengram@cox.net
Gita Enders	Individuals in Recovery (from Mental Illness and Addictions)		3400 East Godard Road, #54A Cottonwood, AZ 86326	genders@gmail.com
Sue Gilbertson	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		3023 East Pershing Phoenix, AZ 85032	sgilbertson@cox.net
Daniel Haley	Individuals in Recovery (from Mental Illness and Addictions)	Hope, Inc.		danielhaley@hopetucson.org

Alida Montiel	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Inter-Tribal Council of Arizona	alidamontiel@itcaonline.com
Joe Mucenski	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	6722 North Quartzsite Canyon Place Tucson, AZ 85718	professors@comcast.net
Sandra Ortiz	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	447 South Meadowood Lane Sierra Vista, AZ 85635	sandilkn@cox.net

Footnotes:

At the time of this application's drafting, the Web Block Grant Application System (WebBGAS) was experiencing technical difficulties preventing the state from adding the information of Planning Council Members who were not associated with a state agency or provider organization. The WebBGAS Help Desk is aware of this problem.

In the interim, the complete Planning Council membership roster has been added as an attachment to the end of this application; members not presently listed in Table 11 will be added prior to official submission to SAMHSA on September 1st, 2011.

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member
Page 52 of the Application Guidance

Start Year: [   ]

End Year: [   ]

Type of Membership	Number	Percentage
Total Membership	30	
Individuals in Recovery (from Mental Illness and Addictions)	6	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	6	
Vacancies (Individuals and Family Members)	4	
Others (Not State employees or providers)	1	
Total Individuals in Recovery, Family Members & Others	17	56.67%
State Employees	8	
Providers	3	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	2	
Total State Employees & Providers	13	43.33%

Footnotes:

At the time of this application's drafting, the Web Block Grant Application System (WebBGAS) was experiencing technical difficulties preventing the state from adding the information of Planning Council Members who were not associated with a state agency or provider organization. The WebBGAS Help Desk is aware of this problem.

In the interim, the complete Planning Council membership roster has been added as an attachment to the end of this application; members not presently listed in Table 11 will be added prior to official submission to SAMHSA on September 1st, 2011.

IV: Narrative Plan

P. Comment On The State Plan
Page 50 of the Application Guidance

Narrative Question:
SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

The Joint Block Grant Planning Section was released for public comment, and posted on the ADHS/DBHS website (http://www.azdhs.gov/bhs), upon the conclusion of the initial drafting process. Pertinent stakeholders, including State partner agencies, the Regional and Tribal Regional Behavioral Health Authorities, members of the Arizona Behavioral Health Planning Council, peer and family run organizations, and front-line services providers were notified via email, and during in-person meetings, of its availability and were encouraged to review its contents and submit comments as necessary. This included more than 4,000 individuals subscribing to the ADHS/DBHS' Office of Individual and Family Affairs' list serve.

Additionally, as seen below, ADHS/DBHS took the added step this year of broadcasting the application's availability via multiple social-media outlets, including an announcement, or "tweet" on the Arizona Department of Health Services Twitter account (@AZDHS) which has approximately 2,700 active followers), and posting on the Department's Facebook page (http://www.facebook.com/azdhs) - approximately 1,200 followers.

STATE OF ARIZONA

JANICE K. BREWER
GOVERNOR

EXECUTIVE OFFICE

May 17, 2010

Barbara Orlando
Grants Management Specialist
Division of Grants Management, OPS
SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Dear Ms. Orlando:

I am designating Will Humble, Director at the Arizona Department of Health Services, as the signature authority for the Substance Abuse Prevention and Treatment Block Grant, the Projects for Assistance in Transition from Homelessness (PATH) and Community Mental Health Services Block Grant. The authority includes the signing of any standard federal forms such as the Assurances, Certifications and Disclosure of Lobbying Activities. I also designate that Mr. Humble shall have signature authority during my term as Governor of Arizona.

If you have any questions, please contact Mr. Humble at (602) 542-1027.

Sincerely,

Janice K. Brewer
Governor

JKB:bkl

Goal 1: Increase the percentage of children who live with their families		Tool	Baseline (FY2012)	Target (FY2017)
		Out of Home (OOH) Utilization Data	Data collection in process for FY2011	10% decrease from baseline

Key Contributing Factors	Objectives	Strategies	Evaluation		
			Tool	Baseline	Target
Accessibility to services	1.1 Increase the percentage of families satisfied with access to services	1.1.1 Monitor the availability of case manager with reduced case loads for children with complex needs 1.1.2 Monitor the availability of generalist direct support providers and specialty providers to deliver flexible, in-home, community based support and rehabilitation services 1.1.3 Monitor data indicators for network sufficiency	Youth Service Survey for Families (YSS-F) Access to Services Domain	83% (FY2010)	90% by FY2017
Quality of Service Delivery	1.2 Expand the use of best practices to improve outcomes	1.2.1 Promote the use of Trauma Informed Care 1.2.2 Promote national and local best practice 1.2.3 Develop an outcome monitoring mechanism based on CASII functional status dimension 1.2.4 Assess Universal Child and Family Team (CFT) Practice to identify opportunities for improvement	YSS-F Outcomes Domain System of Care Practice Review (SOCPR) – Domain 4: Impact[1]	68% (FY2010) 4.94 (FY2010)	80% by FY2017 5.5 by FY2017
	1.3 Improve assessment and service planning	1.3.1 Increase fidelity in identification of children with complex needs 1.3.2 Implement Required Elements for Assessment and Service Planning	Arizona Health Care Cost Containment System (AHCCCS) Performance Measures: Service Provision and Service Planning	Data collection in process for FY2011	Service Provision and Service Planning 90% by FY2017

Children's System of Care Logic Model for SFY 2012 to SFY 2017

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS)
Children's System of Care (CSOC) Strategic Plan/Logic Model

6/28/11

Key Contributing Factors	Objectives	Strategies	Evaluation		
			Tool	Baseline	Target
	1.4 Service delivery is respectful of culture and attuned to how family decisions are influenced by culture	1.4.1 Work with Tribal/Regional Behavioral Health Authorities (T/RBHAs) to create specific workforce development, training, and coaching plans to address needs identified by practice review results and other indicators	SOCPR Domain 3: Culturally Competent[2]	4.79 (FY2010)	5.5 by FY2017
Embedded Youth and Family Involvement in the System of Care	1.5 Increase youth and family roles	1.5.1 Develop minimum network expectation for peer delivered family support 1.5.2 Standardize minimum competencies of peer delivered family support 1.5.3 Increase opportunities for family and youth involvement at all levels of the System of Care	Network Inventory	Data being extracted from FY2011 Network Inventory	To be established by FY2012
	1.6 Increase access to Family Run Organizations	1.6.1 Establish mechanisms to connect families to Family Run Organizations 1.6.2 Support RBHAs and providers in developing and maintaining a tracking process for referrals to Family Run Organizations	Number of GSAs with referral tracking mechanism	1 GSA (FY2011)	6 GSAs by FY 2013
Coordination with Child Serving Agencies	1.7 Improve collaborative efforts with other child serving agencies	1.7.1 Facilitate ongoing collaboration mechanisms with system partners 1.7.2 Establish a mechanism to share data on children receiving services in Out of Home settings	Overall SOCPR results[3] RBHA Quarterly Appeal tracking for subcategory DES/CPS	5.16 (FY2010) DES/CPS subcategory added FY2012	6 (FY2017) 10% decrease from established baseline by FY2014

[1]ADHS/DBHS FY2010 SOCPR Summary Report; FY2010 Summary Report
[2]IBID
[3]Op. Cit.

Children's System of Care Logic Model for SFY 2012 to SFY 2017

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS)
Children's System of Care (CSOC) Strategic Plan/Logic Model

6/28/11

Goal 2: Increase the percentage of youth who experience educational success	Tool	Baseline (FY2010)	Target (FY2017)
	Education National Outcome Measure (NOM) for children 5-18	92.6%	95%

Key Contributing Factors	Objectives	Strategies	Evaluation		
			Tool	Baseline	Target
School involvement in CFT practice	2.1 Increase knowledge about the education system	2.1.1 Coordinate with the Arizona Department of Education (ADE) to identify barriers and solutions to collaboration between behavioral health care and education 2.1.2 Promote joint service planning through CFT practice that involves behavioral health and schools 2.1.3 Provide information to families on the structure of Arizona's Education system and Federal and State Requirements	Training pre and post test of educational system knowledge	Each pre test with its own baseline	5% from baseline
School Climate	2.2 Improve school climate	2.2.1 Implement At-Risk training for High School Educators 2.2.2 Implement Mental Health First Aid training initiative with a focus on educational settings 2.2.3 Identify strategies to decrease stigma on school campuses through The Stigma Reduction Committee and other efforts	Prevention training exit survey of people who complete trainings	Each pre test with its own baseline	10% improvement from pre test or retro test

Children's System of Care Logic Model for SFY 2012 to SFY 2017

Goal 3: Increase the percentage of youth who transition to a successful adulthood	Tool	Baseline (FY2010)	Target (FY2017)
	NOMs for 18-21 year olds	Employment 11%	15%
		Stable Housing 92.7%	95%
		Arrest Free 87.4%	90%
		Substance Abstinence 32.3%	40%

Key Contributing Factors	Objectives	Strategies	Evaluation		
			Tool	Baseline	Target
Family Involvement	3.1 Increase peer and family support services provided for transition aged youth and their families	3.1.1 Promote education for youth and families on the availability of family and peer support services 3.1.2 Promote opportunities for collaboration between peer-run and family-run organizations	Peer Delivered Service Utilization	To be extracted from DBHS service utilization data by FY2012	To be established by FY2013
Youth Empowerment	3.2 Increase opportunities for youth involvement and empowerment	3.2.1 Implement the ADHS/DBHS Youth Practice Protocol 3.2.2 Host Arizona Dialogues and roundtables on youth issues 3.2.3 Increase youth participation and influence in service planning 3.2.4 Promote the expansion of youth involvement/roles at all levels of the system of care	SOCPR Child Centered and Family Focused Youth Positions on Network Inventory	5.25 (FY2010) Data being extracted from FY2011 Network Inventory	6 by FY2017 To be established by FY2012
Quality of Service Delivery	3.3 Improve service delivery for transition age youth	3.3.1 Participate as a member of the Arizona Community of Practice on Transition to support collaborative efforts with respect to transition age youth 3.3.2 Promote the use of best practices with transition age youth	AHCCCS Performance Measures: Service Provision and Service Planning for 18-21	Data collection in process for FY2011	Service Provision and Service Planning 90% by FY2017

Children's System of Care Logic Model for SFY 2012 to SFY 2017

Goal 4: Decrease youth substance use	Tool	Baseline (FY2010)	Target (FY2017)
	Treatment Substance Abstinence NOM[4]	37.8%	42%
	AYS 30 day use of :[5] Alcohol	31.9%	28%
	Marijuana	29.9%	26%
	Prescription Drugs	21.5%	17%

Key Contributing Factors	Objectives	Strategies	Evaluation		
			Tool	Baseline	Target
Family support and involvement	4.1 Increase the percentage of youth who state that they have spoken with their parents about alcohol and drug use.	4.1.1 Incorporate Draw the Line (DTL) messages into all prevention programs inclusive of parents	AYS[6]	30.5% (alcohol, FY2010)	35% (alcohol, FY2016)
				38.1% (drugs, FY2010)	45% (drugs, FY2016)
Perception of harm	4.2 Increase youth perception of harm of alcohol use and marijuana use	4.2.1 Incorporate education on perception of harm into prevention programs	AYS [7]	62.8% (alcohol, FY2010)	69% (alcohol, FY2016)
				71.0% (marijuana, FY2010)	77% (marijuana, FY2016)
				Baseline for prescription drugs to be established fall 2011 based on DBHS core adolescent survey	Target to be established in fall 2011 based on core survey

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[4] http://www.azdhs.gov/bhs/dashboard/scorecard_adult-child.htm

[5] Arizona Youth Survey (AYS)

[6] % of youth who indicated communication with parents about alcohol or drugs

[7] % of youth who perceive that using alcohol daily or marijuana regularly, or prescription drugs for the purpose of getting high places people at "moderate or great risk"

Children's System of Care Logic Model for SFY 2012 to SFY 2017

Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS)
Children's System of Care (CSOC) Strategic Plan/Logic Model

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Key Contributing Factors	Objectives	Strategies	Evaluation		
			Tool	Baseline	Target
Access to effective care for substance use disorders	4.3 Increase the number of youth appropriately identified with substance abuse (SA) needs	4.3.1 Standardize the process for screening youth for substance use disorders	Client Information System (CIS) [8]	7.4% (FY2010)	10% (FY2017)
	4.4 Increase the number of hospital Emergency Departments (EDs) using Screening, Brief Intervention, and Referral to Treatment (SBIRT) with youth.	4.4.1 Implement ADHS/DBHS Emergency Department Initiative	Survey of hospitals (baseline to be established)	Data collection in process for FY 2011	10% improvement from baseline annually
	4.5 Increase the number of behavioral health staff who use at least 1 evidence based practice in substance abuse treatment	4.5.1 Coordinate training and workforce development in evidence based practices	Annual Network Inventory	84% (FY 2011)	95% by FY 2014
Opportunity for Community Involvement	4.6 Increase the percentage of DBHS funded prevention programs which are incorporated into a community coalition as evidenced by a comprehensive community (coalition) strategic plan	4.6.1 Provide training and technical assistance to coalitions 4.6.2 Conduct Needs, resource, and gap analysis of the Arizona-Sonora border region	Annual Prevention Program Evaluation	To be established in FY 2012 based on prevention end of year report submitted 9/30/11	80% by FY 2014
	4.7 Decrease youth access to alcohol and prescription drugs	4.7.1 Collaboration with the Community Prevention Substance Abuse Work Group (CPSAWG) and Arizona Substance Abuse Partnership (ASAP)	AYS (% of youth who perceive alcohol as "easy" or "sort of easy" to get)	59.3% (FY 2010)	54% by FY 2014

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[8] Number of youth who have a SA diagnosis

Children's System of Care Logic Model for SFY 2012 to SFY 2017

Page 6

	Tool	Baseline (Calendar Year 2009)	Target (Calendar year 2017)
Goal 5: Decrease statewide rates of youth suicide completion	Arizona Vital Statistics, suicide completions for youth, ages 15 to 19	10.7 per 100,000	10 per 100,000, age adjusted

Key Contributing Factors	Objectives	Strategies	Evaluation		
			Tool	Baseline	Target
Social Connection/ Sense of Purpose	5.1 Increase connections to natural supports	5.1.1 Promote efforts to create connections to natural supports in service planning 5.1.2 Establish a marketing campaign on natural support resources 5.1.3 Collaboration with the Statewide Suicide Prevention Coalition, Statewide Injury Prevention Coalition, and the Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) Advisory Committee	Referrals to Teen Life Line YSS-F Social Connectedness Domain	Baseline to be established (FY 2012) 88% (FY2010)	10% increase from baseline by FY2017 90% by FY2017
Early Identification of warning signs indicative of suicidal risk	5.2 Increase comfort and ability of families, youth, community members, peers, family support organizations, first responders, and prevention providers to intervene in suicide and make referrals to behavioral health services	5.2.1 Support and monitor Suicide prevention gatekeeper training 5.2.2 Implement Mental Health First Aid training initiative	Suicide Prevention Training Exit Survey	Mean pre/retro test score	5% increase from baseline

Children's System of Care Logic Model for SFY 2012 to SFY 2017

Key Contributing Factors	Objectives	Strategies	Evaluation		
			Tool	Baseline	Target
Cultural Disparities	5.3 Increase competency of prevention and behavioral health providers in provision of effective and culturally responsive care	5.3.1 Training for prevention and treatment providers in mental health care for youth 5.3.2 Develop advanced training in cultural competency and groups with disparities 5.3.3 Increase education about underrepresented /underserved populations 5.3.4 Conduct Arizona Dialogues on issues surrounding suicide	Training post-retro	Baseline individualized per training	5% from baseline

Children's System of Care Logic Model for SFY 2012 to SFY 2017

Arizona Department of Health Services/Division of Behavioral Health

Adult System of Care Strategic Plan

FY 2012 – FY 2014

Key Areas include:

Health Integration

Substance Abuse Prevention & Treatment

Employment

Suicide Prevention & Early Intervention

Trauma Informed Care

Peer & Family Support

Peer, Family, and Community Participation

Health Integration

Goal:
To enhance the physical health of *all* adult behavioral health recipients

Contributing Factors	Objectives	Strategies	Evaluation Tools	Baseline	Targets	Targets	Targets
	Specific, time limited, measureable statements which correspond directly to the adjacent contributing factor	What specific projects, activities, initiatives, and/or strategies will ADHS/DBHS engage in to achieve the objective?	How will we know if we have achieved the objective?		2012	2013	2014
75% of people with serious mental illness in Arizona use tobacco (QHI, 2010)	Reduce tobacco use in the behavioral health recipients by 15% by 2014	1. Develop a mechanism to assess tobacco use in behavioral health recipients 2. Collaborate with TEPP to provide technical assistance to RBHAs in developing cessation plans including promotion of the quit line. 3. Incorporate provision of information about the quit line as an interim service into the provider manual.	Ask TEPP how they are estimating prevalence	75% among people who have a serious mental illness (QHI, 2010)	70%	65%	60%
Coordination/ integration of services	Increase coordination of behavioral health recipient care with PCPs	1. Monitor RBHA Coordination of Care programs through administrative review.	Dashboard measure on % Coordination of Care	85% (2010)	90%	92%	95%
Capacity of behavioral health workforce to incorporate physical health	Increase behavioral health staff knowledge of health related topics and connection between physical and mental health	1. Conduct on line training series on co-occurring physical and mental health condition among BH recipients, including specialized topics for peer and family support providers. 2. Implement Quarterly Health initiatives(QHI)	Pre and post of staff knowledge and attitudes administered in conjunction with education.	Baselines established with individual trainings	5% increase		

Substance Abuse Treatment and Prevention

Goal:
Improve overall quality, effectiveness, and access to services for individuals with a substance use disorder (SUD).

Contributing Factors	Objectives	Strategies	Evaluation Tools	Baseline	Targets	Targets	Targets
	Specific, time limited, measureable statements which correspond directly to the adjacent contributing factor	What specific projects, activities, initiatives, and/or strategies will ADHS/DBHS engage in to achieve the objective?	How will we know if we have achieved the objective?	2011 or earlier	2012	2013	2014
Access to treatment	1. Increase enrollment & penetration rates for pregnant females and females with dependent children, with a substance use disorder/dependence (SUD). 2. Increase enrollment & penetration rates for Intravenous Drug Users (IVDU) [1] 3. Increase enrollment and penetration rates for older adults – ages 55 and over.	a. Monitor women's & IV Drug Users on-line wait list b. Monitor RBHA outreach and engagement efforts c. Continue collaboration with other state agencies e.g. ADE, ADC, ADJC, AOC, DCYF, AZDHS Division for Women's & Children's Health and DDD d. Complete ADHS/DBHS Older Adult Treatment Protocol; online training	CIS Demographic Data	9,777 or 13.9% of SA pop (SFY 2010) 5,125 or 7.3% of SA pop (SFY 2010) 5,838 or 8.3% of SA pop (SFY 2010)	Increase by 5% annually Increase by 5% annually Increase by 10% annually		
	4. Increase medical providers knowledge and comfort level in making referrals for substance abuse treatment	a. Collaborate with AZ Poison Control to develop a referral mechanism for people who poison more than once. b. Provide hospital access to Kognito ED training c. Distribute the ED Intervention and Referral Manual; Decision tree posters; and pocket screeners	# trained Pre and post tests after training	To be established in 2011	To be determined (TBD)	TBD	TBD

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[1] IVDU is defined as those individuals with a substance use disorder/dependence who indicate, 'injection' as the route of use for their primary, secondary, or tertiary substance type.

Goal:							
Improve overall quality, effectiveness, and access to services for individuals with a substance use disorder (SUD).							

	1. Increase the use of evidence based practice in delivery of substance abuse treatment services.	a. Contractually mandate and implement the statewide use of the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC 2 R).	ASOC plan progress updates	0.4%	90%	90%	90%
Use of effective interventions for screening, assessment, referral, placement and use of evidence based practices		b. Implement the Clinical Practice Protocol for adult consumers with a substance use disorder/dependence	Annual Network Inventory (percentage of BHTs, BHMPs, BHPs who report use of at least one EBP in addition to ASAM)	TBD	50%	75%	90%
	2. Improve treatment completion rates for all persons with a substance use disorder/dependence	a. Define treatment completion and establish performance baseline rates.	CIS Demographic data	Establish Baseline	TBD	TBD	TBD
		b. Monitor engagement and re-engagement efforts through an annual Independent Case Review (ICR)	ICR	70.4%	Increase by 5% annually		
	3. Decrease disparities in treatment outcomes	a. Analyze NOMS[2] outcomes data for all populations with Substance Use Disorders. b. Analyze NOMS outcomes data by gender, race, age, ethnicity, sexual identity, and sexual orientation c. Compare findings of (A) & (B) d. Perform root cause analysis to identify reasons for disparities if any.	NOMS Data	Establish baseline FY11	TBD	TBD	TBD
	4. Increase the availability and service utilization of Medication-Assisted Treatment (MAT) options [3]	a. Institute a pilot program using SAPT Block Grants funds for Medication Assisted Substance Use Treatment b. Monitor Utilization data c. Monitor network capacity / network inventory	Utilization data of consumers with an SUD & utilizing MAT	7.8% - or 78.21 of per 1,000 calendar yr. 2009)	Increase by 2% annually		

[2] NOMS data includes: employment, education participation, homelessness, criminal activity, substance use, and self-help participation
[3] Such as Methadone, Buprenorphine, Campral, Naltrexone, and Suboxone

Goal:					
Improve overall quality, effectiveness, and access to services for individuals with a substance use disorder (SUD).					
	5. Increase the use of peer services in substance abuse treatment	a. Monitor use of peer services for substance abuse population.	Utilization data	8,169 or 11.6% of SA pop (FY10)	Increase by 5% annually

Employment

Goal:							
Increase and retain employment of members served by the behavioral health system							
Contributing Factors	**Objectives**	**Strategies**	**Evaluation Tools**	**Baseline**	**Targets**	**Targets**	**Targets**
	Specific, time limited, measureable statements which correspond directly to the adjacent contributing factor	What specific projects, activities, initiatives, and/or strategies will ADHS/DBHS engage in to achieve the objective?	How will we know if we have achieved the objective?		2012	2013	2014
Education for Providers	1. Increase the total number of Provider staff trained on Social Security Work Incentives, including the Ticket to Work Program and Freedom to Work Program.	a. Provide Social Security Work Incentive training to all staff that provide vocational services, Case Managers, Peer Support Specialists, and Benefits Specialist, where applicable. b. Roll out training on DB101 in FY2012. c. Post Work Incentives information on the DBHS website, including DB101.	Monitor RBHA Quarterly Rehab Progress Reports.	Total number of attendance in Work Incentives trainings during FY2011.	Increase total number of people trained by 20%.	Increase total number of people trained by 20%.	Increase total number of people trained by 20%.
	2. Increase employment rates for the Serious Mental Illness (SMI), General Mental Health (GMH), and Substance Abuse (SA) populations.	a. DBHS will prescribe content of future DUG training.	Analyze CIS data	Benchmark pending NOMS analysis for FY2011, which will be analyzed in November, 2011.	2% increase in Employment Rates for each population (SMI, GMH, and SA).	2% increase in Employment Rates for each population (SMI, GMH, and SA).	2% increase in Employment Rates for each population (SMI, GMH, and SA).

Use of effective supports	1. Increase the utilization of Psycho-educational Services (H2027) and Ongoing Support to Maintain Employment (H2025)	a. RBHAs will have dedicated staff to provide vocational services. Dedicated staff will direct 100% of their job duties toward vocational services. b. Revise Network Inventory instructions to collect the number of dedicated staff that are responsible for the provision of vocational services.	1. Review Network Inventory 2. Review of utilization data	FY2011 utilization data.	Increase utilization rates of H2027 for enrolled members by 10%. Increase utilization rates of H2025 for employed members by 10%.	Increase utilization rates of H2027 for enrolled members by 10%. Increase utilization rates of H2025 for employed members by 10%.	Increase utilization rates of H2027 for enrolled members by 10%. Increase utilization rates of H2025 for employed members by 10%.
	2. Increase number of Employment Networks through the Social Security Ticket to Work Program.	a. Provide education to Provider Leadership on the benefits of becoming an Employment Network. b. Establish a local Arizona Employment Network Association through collaborative efforts with Arizona Bridge to Independent Living (ABIL). c. Review of registered Employment Networks in the Maximus website.	1. Quarterly Regional Vocational Meetings. 2. Maximus website.	Current numbers of Employment Networks who work with Behavioral Health Social Security benefit recipients.	Increase the number of Behavioral Health Employment Networks statewide by 4. Establish the local Arizona Employment Network Association	Increase the number of Behavioral Health Employment Networks statewide by 4.	Increase the number of Behavioral Health Employment Networks statewide by 4.

Suicide Prevention and Early Intervention

Goal:
Reduce the Arizona suicide rate from 16.1 per 100,000 (age adjusted) to 14.0 per 100,000.

Contributing Factors	Objectives	Strategies	Evaluation Tools	Baseline	Target 2012	Target 2013	Target 2014
Early Identification of suicide risk	1. Increase comfort and ability of families and communities to identify potential risk and make referrals to BH treatment	1.1 Provide training for service members, veterans, and their families in recognizing signs of PTSD and TBI and the referral process 1.2 Online training for college professors and students in identifying and referring persons potentially at-risk 1.3 Collaborate with the Department of Economic Security in distributing awareness materials	Suicide Prevention Training Exit Survey (TES)	To be established fall of 2011	Baseline Mean pre test score	5% increase from baseline	10% increase from baseline
		1.4 Training for medical professionals in screening and assessment for suicide	Early Identification and Referral form (EIRF)	To be established fall of 2011	Baseline # of referrals to TX	5% increase from baseline	10% increase from baseline
	2. Increase comfort and ability of poison control center staff to intervene with attempters and make referrals to BH treatment	2.1 Conduct ASIST training with poison control center staff	TES	To be established fall of 2011	Baseline Mean pre test score	5% increase from baseline	10% increase from baseline
		2.2 Develop an outreach strategy to reduce multiple overdoses	EIRF	To be established fall of 2011	Baseline # of referrals	5% increase from baseline	10 % increase from baseline
Quality of Service Delivery	3. Increase T/RBHA and BH provider organizations capacity to respond to and provide services after a suicide.	c. Develop DBHS recommendations for responding to and providing services after a suicide	Number of T/RBHA's with a policy or protocol	To be established by spring of 2012	Baseline established	100% of RBHAs	100% of RBHAs and providers
	4. Increase ability and comfort of BH providers to provide culturally competent services for service members, veterans, and their families	d. Collaborate with the Arizona Coalition for Military Families, the VA, and stakeholders to develop advanced training in cultural competency with military families for BH providers e. Provide access to the At-Risk training for families of veterans	Training post test	To be established	Baseline	5% increase from baseline	10% improvement from baseline
	5. Improve collection of information about suicide attempts and completions	f. Collaborate with State Fatality Review program to adapt or create a standardized checklist for collection of data on adult suicides	Number of organizations adapting the checklist	To be established	Baseline	5% increase from baseline	10% increase from baseline

Trauma Informed Care

Goal: Integrate the Trauma Informed Care philosophy throughout all levels of the public behavioral health system.							
Contributing Factors	**Objectives**	**Strategies**	**Evaluation Tools**	**Baseline**	**Targets**	**Targets**	**Targets**
	Specific, time limited, measureable statements which correspond directly to the adjacent contributing factor	What specific projects, activities, initiatives, and/or strategies will ADHS/DBHS and T/RBHA engage in to achieve the objective?	How will we know if we have achieved the objective?	2011 or earlier	2012	2013	2014
Awareness	1. Increase knowledge and appreciation of the prevalence of trauma and the impact of trauma 2. Incorporate knowledge about trauma—prevalence; impact, and multiple, diverse paths to recovery—in all aspects of service delivery and practice.	1. Conduct statewide TIC Dialogues to, create awareness and assess community needs around trauma informed care 2. Provide training and education on trauma and trauma informed care across system 3. Develop a plan to incorporate TIC in human resource practices, policies, procedures, and other tools. 4. Incorporate the use of social media and other venues to increase public knowledge and awareness of trauma informed care.	1. Pre and Post survey 2. # of attendees at the trainings and dialogues 3. Other measures TBD based on the statewide needs assessment.	TBD based on the statewide needs assessment			
Collaboration	1. Community participation; by collaborating with peers and family members, CSAs, and behavioral health providers, through creating awareness and sharing responsibility 2. Increase knowledge and engagement of senior leadership in trauma informed care philosophy. 3. Collaboration between system partners to incorporate knowledge about trauma and	1. Conduct needs assessment through statewide TIC dialogues. a. Identify top priorities based on needs assessment and develop a work plan 2. Increase partnerships with CSAs to educate, advocate, and support trauma informed care 3. Conduct cost/benefit analysis through a pilot project.	1. Needs assessment 2. Work plan reflecting priorities identified in the needs assessment 3. TBD based on the statewide needs assessment and priorities	TBD based on the statewide needs assessment			

Goal: Integrate the Trauma Informed Care philosophy throughout all levels of the public behavioral health system.							
	trauma informed care in all aspects of service delivery and practice.						
Safety	**Individual receiving services -** 1. Staff at all levels of the service environment should be trained, aware and sensitive to and have an understanding of trauma informed care. 2. The service environment should be driven by the voices and choices of children, youth, adults, and their families 3. Services are provided in an environment where there is a sense of trust which creates an environment of safety and stabilization **Individuals providing services -** 4. Ensure physical and emotional safety for staff members throughout our system of care 5. Maximize collaboration and sharing of power with staff members 6. Prioritize staff empowerment and skill-building at every opportunity. 7. Provide resources to staff to assist with implementing and understanding TIC.	1. Empower peers and family members through education on trauma informed care. 2. Create opportunities to include peer and family members in all levels of decision making within the service environment. 3. Organizational policies and procedures should reflect attention to trauma informed care. 4. Empower staff through training such as de-escalation techniques. 5. Review assault /crisis trainings including seclusion and restraint practices provided by T/RBHAs and/or behavioral health providers to determine whether training includes the tenants of trauma informed care. 6. Support and supervision to staff at all levels of care. 7. Provide shared decision making with staff. 8. Create and provide opportunities and resources for empowerment, including, but not limited to front line staff, through trainings, conferences, peer to peer consult, and classes.	TBD based on the statewide needs assessment	TBD based on the statewide needs assessment			

Peer & Family Support Services

Goal:							
Increase the use of Peer and Family Support Services for all populations.							
Contributing Factors	**Objectives**	**Strategies**	**Evaluation Tools**	**Baseline**	**Targets**	**Targets**	**Targets**
	Specific, time limited, measureable statements which correspond directly to the adjacent contributing factor	What specific projects, activities, initiatives, and/or strategies will ADHS/DBHS engage in to achieve the objective?	How will we know if we have achieved the objective?		2012	2013	2014
Accessibility of Services	1. Increase the percentage of Peers and Family Members satisfied with access to services	1. Monitor data indicators for network sufficiency 2. Monitor the availability of trained/credentialed Peer and Family Support Specialists 3. Monitor service recipient participation in the development of ISP goals and service selection.	Annual Network Analysis Customer Satisfaction Survey/MHSIP Annual Chart Reviews		ongoing	ongoing	ongoing
	2. Increase the number of referrals made to Peer and Family Run Organizations	1. Monitor mechanisms to promote the connection of Peers and Family Members to Peer and Family Run Organizations 2. Support T/RBHA's and providers in developing and maintaining a tracking process for referrals to Peer and Family Run Organization 3. Support the T/RBHA's and Peer and Family Run Organizations in the development of a mechanism for Behavioral Health recipients to self refer for Peer and Family Support Services	Completed T/RBHA plan for tracking referrals Tracking Tool Completed T/RBHA plan for self-referral T/RBHA Bi-Annual & annual Update Reports		Completed tracking plan		

	3. Increase Peer and Family Support Services provided for transition aged youth.	1. Promote educational opportunities for transition aged youth and families on Peer and Family Support Services and resources 2. Encourage T/RBHA's, providers and Peer and Family Run Organizations to partner in the development of collaborative opportunities to educate on transition to adult services and resources 3. Monitor utilization data related to the service codes H0038, H0038 HQ, H2016 and S5110	Utilization data		Establish baseline data	TBD	TBD
Quality of Service Delivery	1. Expand the use of best practices to improve outcomes	1. Provide technical assistance to T/RBHA's and providers to develop specific workforce development and coaching plans to promote the implementation of Trauma Informed Care 2. Encourage use and expansion of national and local best practices specific to peer and family support.	T/RBHA Bi-Annual and Updates				
	2. Service delivery is respectful of culture and attuned to how decisions are influenced by culture	1. Monitor that service plans reflect the behavioral health recipient's cultural preferences (for example, values, traditions, beliefs, race, language, etc.)	Customer Satisfaction Survey/MHSIP	FY201o Survey data	Increase Satisfaction rate by 2% annually	Increase Satisfaction rate by 2% annually	Increase Satisfaction rate by 2% annually
	3. Increase the utilization of Peer and Family Support specialist Services	1. Monitor utilization data related to the service codes H0038, H0038 HQ, H2016 and S5110	Review of Utilization data	FY2011 Utilization data	Increase Utilization rate by 5% annually	Increase utilization rate by 5% annually	Increase utilization rate by 5% annually
Collaboration	1. Improve collaborative efforts with Peer and Family Run Organizations	1. DBHS OIFA office to provide technical assistance to peer and Family Run Organizations to explore strategies for developing joint collaboration efforts between peer and			ongoing	ongoing	ongoing

		family run organizations. 2. Promote awareness regarding the need for connections to natural support systems and resources, i.e. faith based organizations, extended family members, self help groups, etc.					

Peer, Family & Community Participation

Goal 1:
Promote collaboration, community involvement, access to, and the inclusion of all community voices in all aspects of the public behavioral health system.

Contributing Factors	Objectives	Strategies	Evaluation Tools	Baseline	Targets	Targets	Targets
	Specific, time limited, measureable statements which correspond directly to the adjacent contributing factor	What specific projects, activities, initiatives, and/or strategies will ADHS/DBHS engage in to achieve the objective?	How will we know if we have achieved the objective?		2012	2013	2014
Safety Voice Awareness Collaboration	1. Partner with First Responders to infuse the Trauma Informed Care (TIC) philosophy, suicide prevention and awareness in their work with the community at large.	a. Promote outreach to invite 1st Responders to participate in TIC Dialogues b. Continue to promote provide Mental Health First Aid (MHFA) training to the statewide community to increase the number of MHFA trainers and training opportunities c. Continue to promote ASIST statewide as suicide awareness and reduction education.	Trauma Informed Care Dialogue Attendance Sheets Mental Health First Aiders Tracking/Sign In Sheets DBHS Events Calendar	N/A FY11 Peer & Family Member totals	10% annual increase	10% annual increase	10% annual increase
	2. Promote opportunities for collaboration between Peer and Family Run Organizations	a. Identify opportunities for collaboration around integrated health care and health homes in partnership with Peer Member Organizations and the Arizona Peer and Family Coalition. b. Collaborate with Peer and Family Run Organizations and Consumer Advisory Councils to develop a mechanism to inform service recipients on how to navigate the changing Adult Behavioral Health System.					

Goal 2:
Promote peer and family member involvement in all aspects of the public behavioral health system.

Contributing Factors	Objectives	Strategies	Evaluation Tools	Baseline	Targets	Targets	Targets
	Specific, time limited, measureable statements which correspond directly to the adjacent contributing factor	What specific projects, activities, initiatives, and/or strategies will ADHS/DBHS engage in to achieve the objective?	How will we know if we have achieved the objective?		2012	2013	2014
Safety Voice Awareness Collaboration	1. Increase the level of Peer, Family and community representation on DBHS, RBHA and provider committees, advisory councils, boards and work groups.	a. T/RBHA's will maintain a listing of core committees as identified in the T/RBHA Annual QM Report, for peers, family member and community participation and representation b. T/RBHA's will develop a mechanism to inform enrolled members of opportunities to join committees, advisory councils, boards, and workgroups. c. DBHS to implement a statewide Peer, Family and Community Member Quality Involvement Survey to measure members' quality of involvement on committees, advisory councils, boards and workgroups.	Database of Available Committees Database of Committee Representation T/RBHA Marketing Plan for Committee Opportunities Database Reports Peer, Family and Community Representative Quality Involvement Survey	Establish Baseline N/A	Increase representation by 50% Completed Plan Establish baseline	Increase by 25% 5% Increase From baseline	Increase by 25% 10% Increase from baseline
	2. Adequately prepare peer & family members for meaningful involvement to act as partners in decision making within the behavioral health system.	a. Develop and deliver training curriculum (orientation training for peers and family members) that is inclusive of identified DBHS approved core elements. b. Promote activities which identify and develop peer and family advocacy and leadership opportunities. c. DBHS to partner with peer and family run organizations to develop training specific to the	a. Training Curriculum Pre-Post Tests Training Evaluation Forms b. DBHS statewide events calendar and Multi-media efforts i.e. twitter, face book, etc.		Orientation Training completed for all current representatives	ongoing	ongoing

		Adult Recovery principles.	c. Training Schedule				

Goal 3:
Promote peer and family integration in all aspects of the community with support of the public Behavioral Health System.

Contributing Factors	Objectives	Strategies	Evaluation Tools	Baseline	Targets	Targets	Targets
	Specific, time limited, measureable statements which correspond directly to the adjacent contributing factor	What specific projects, activities, initiatives, and/or strategies will ADHS/DBHS engage in to achieve the objective?	How will we know if we have achieved the objective?		2012	2013	2014
Safety Voice Awareness Collaboration	1. Increase the number of Behavioral Health Service Recipients, with an emphasis on Transition Aged Youth, who are registered to vote in State and Federal elections	a. Promote existing education and marketing campaigns around the concept of voting b. Encourage Adult and TAY and SMI Populations to attend community events to understand voting issues and voter registration	DBHS Announcements & Calendar DBHS Announcements & Calendar		Ongoing	Ongoing	Ongoing
	2. Collaborate with Educational Institutions to integrate the Recovery Philosophy in current and future programming.	a. Market presentations to colleges and universities to increase awareness of Recovery, Stigma and Community Integration. b. Develop strategies to increase opportunities for internships within DBHS.	Presentation schedule DBHS Announcements Calendar		Ongoing	Ongoing	Ongoing
	3. Improve successful employment outcomes through stigma awareness and reduction education	a. Promote stigma reduction in the workplace through presentations b. Promote Mental Health First Aid to the business community	DBHS Announcements Calendar		Ongoing	Ongoing	Ongoing
	4. Improve attitudes within the medical community (paramedics, ER staff, PCP's, nurses and pharmacists) about behavioral health in order	a. Market stigma reduction presentations to the medical community b. Promote involvement of the medical and psychiatric community in AZ Dialogues	DBHS Announcements Calendar Sign-In Sheets		Ongoing	Ongoing	Ongoing

	to reduce stigma		throughout the state c. Encourage Peer and Family Run Organizations' utilization of medical interns for their whole health and other programming				
Community Integration	1. Identify strategies to continue to decrease stigma	a. Promote community participation in Arizona Dialogues, Mental Health First Aide and other stigma reduction programming b. Monitor ISP's for inclusion of natural and community supports/activities that foster community integration (i.e., gyms, parks and recreation programs, non-credit internet classes, YM/WCA, libraries, volunteer opportunities, etc.)	AZ Dialogues Annual Schedule Attendance Sheets for AZ Dialogues Mental Health First Aide Attendance Tracking Sheet Annual Chart Reviews		Ongoing	Ongoing	Ongoing

ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
150 North 18th Avenue, 2nd Floor
Phoenix, Arizona 85007

August 27, 2011

Ms. Barbara Orlando
Grants Management Specialist
Division of Grants Management, OPS
SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20850

Dear Ms. Orlando:

The Arizona Behavioral Health Planning Council is required by Public Law 103-321 to review Arizona's Mental Health Services Plan for Children and Adults for Fiscal Year 2012. This must occur before it is submitted to the United States Department of Health and Human Services (DHHS) so that Arizona may receive the federal Mental Health Block Grant for FY 2012. The Planning Council is required to submit a letter or report to the Center for Mental Health Services that may include Council recommendations for modifications to the Plan regardless of whether or not the State accepts those recommendations. Pursuant to these guidelines, the State Plan and Council letter are submitted to the Center for Mental Health Services, U.S. Department of Health and Human Services.

Arizona continues to experience tumultuous economic circumstances. The Planning Council continues to be concerned with the impact this crisis is having on those with behavioral health needs. In SFY 2011, Arizona passed legislation which effectively reduced the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid program, budget by more than $1.5 billion. Governor Brewer submitted a Medicaid Reform Plan to DHHS for approval which was granted in July 2011. This plan makes drastic changes to Arizona's Medicaid eligibility and programs that may result in a loss of benefits for more than 160,000 Arizonans. These changes include provider rate reductions, phase out of Medical Expense Deduction (MED) program, freeze on AHCCCS Care enrollment (childless adult program), mandatory co-payments for parents and children, financial penalties for no-shows, new benefit limitations, elimination of non-emergency transportation and requirement of a 6 month re-determination of eligibility. As a result of these changes, the Council fears that persons in Arizona will lose or face barriers to accessing behavioral health and substance abuse services.

The Council remains concerned that these changes combined with those experienced in SFY 2010 could result in increased homelessness, particularly among the SMI population. Previous budget cuts to supported housing, crisis services and services to the Non-Title XIX SMI population could have serious consequences. This may include an increase in contact between those with behavioral health needs and the criminal justice system and hospital emergency rooms.

The impact of rate reductions and other fiscal constraints has already impacted services. Throughout the state, communities are experiencing behavioral health office closures, staff layoffs, change in provider roles, reduction in services, higher case loads, and challenges accessing services.

"...to advise, review, monitor, and evaluate all aspects of the development of the State Plan"
(Public Laws 99-660, 100-639, and 102-321)

Some peer run organizations report that they are experiencing a significant increase in calls requesting services and to the warm line as members are losing services through behavioral health service agencies. In December 2010, Cenpatico was awarded the RBHA contract for the southeastern area of Arizona (GSA-3) which has resulted in system and provider changes. Additionally, Arizona's freeze on KidsCare (Title XXI) remains intact making services inaccessible to many low income working families.

There have been other significant events impacting ADHS/DBHS' response to many of the challenges Arizona is facing. Arizona passed into law the State Housing Trust Fund which, effective July 1, 2011, requires that ADHS develop a permanent housing program for adults with serious mental illness. Additionally, Arizona experienced the tragic shooting of Congresswoman Gabriel Giffords. This event brought to light the necessity of accessible behavioral health crisis services. As a result, Arizona promptly implemented Mental Health First Aid training which has now become accessible throughout the state for essential members of local communities. In October 2010, AHCCCS modified its enrollment process which now automatically enrolls Medicaid eligible into a RBHA. It was anticipated that this will improve accessibility to Title XIX services.

While many state government agencies were required to take furlough days last fiscal year, this requirement was eliminated for SFY 2012. However, ADHS/DBHS continues to operate with a high staff vacancy rate.

Despite these budgetary challenges, the Planning Council recognizes the increased efforts of ADHS/DBHS to develop wellness programs that integrate physical and mental health such as Camp Wellness, For the Health of IT and the Quarterly Health Initiative. Additional programs have opened in Arizona such as Mountain Health and Wellness that combines primary medical, pharmaceutical and behavioral health providers at one facility. The Planning Council is working with ADHS/DBHS to support these efforts.

Throughout the state, peer and family-run organizations are making concentrated efforts to address employment issues of members and offer youth services. In recognition of integrated health care, the Council and the Department of Health should advocate for the retention and integration of the advances Arizona has made including involvement and employment of peers and family members in the system and shift of the system to a recovery model.

Arizona passed legislation that is intended to reduce cumbersome barriers to becoming licensed as a behavioral health provider. Another hopeful system initiative is the introduction to trauma-informed care. Dialogues throughout the state have already begun with behavioral health members, families, stakeholders and providers.

In response to provider concerns, DBHS has made several significant changes to requirements with the Child and Family Team process, behavioral health assessment tools and the Urgent Response referral system for child welfare. These were aimed to reduce the paperwork and labor intensive efforts.

The Planning Council recommends that ADHS/DBHS work closely with the Council to achieve a better blending of substance abuse and behavioral health planning.

The Council continues to recognize the efforts made by ADHS/DBHS Executive Management to include Behavioral Health Planning Council members in the planning, leadership, and the implementation process as the Division works to implement the concepts presented in evidence based practices. We are hopeful that this relationship continues. We are also supportive of the Division's work to make data accessible to the Council as well as the opportunities for training to Council members, including NAMPHAC technical assistance. The Council met with a NAMPHAC member at its retreat on September 22, 2010 and subsequent retreat on December 8, 2010.

The Council continues its work in education and advocacy. The Children's Committee drafted a white paper that reflected its survey of behavioral health recipients, providers and RBHAs throughout the state to address extended stays in emergency departments for children in a psychiatric crisis. The Committee will submit this paper and its recommendations to the ADHS/DBHS Deputy Director.

The Community Advisory Committee developed 9 Guiding Principles for the delivery of adult services. In addition, advocacy efforts of the Community Advisory Committee have included raising awareness for childless adults who are at risk of losing their AHCCCS eligibility.

The Council continues to travel to rural areas of the state, as well as meeting in the metropolitan areas of Phoenix and Tucson, to provide members with an overview of the existing system and has facilitated input from all regions into state planning activities.

The Planning Council continues to work to be an effective and efficient working group. Its membership extends across the state and also reflects the diversity of our state and the diversity of populations served in the Arizona behavioral health system. The Council also formed an ad hoc Rules Committee to address questions and concerns that may be raised regarding meeting procedures and Council by-laws.

Thank you for the opportunity to provide comment on the State Mental Health Plan. The Council continues its mission to review, monitor, and evaluate all aspects of the development of this Plan.

Sincerely,

AER for

AER for

Vicki Johnson

Mark Ewy

Vicki Johnson
Chair, Planning Council

Mark Ewy
Chair, Planning & Evaluation Committee

ANNUAL SYNAR REPORT

42 U.S.C. 300x-26

OMB № 0930-0222

FFY 2012

State: Arizona

Table of Contents

INTRODUCTION

The Annual Synar Report (ASR) format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 U.S.C. 300x-26) and the Tobacco Regulation for the SAPT Block Grant (45 C.F.R. 96.130 (e)).

Public reporting burden for the collection of information is estimated to average 15 hours for Section I and 3 hours for Section II, including the time for reviewing instructions, completing and reviewing the collection of information, searching existing data sources, and gathering and maintaining the data needed. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to SAMHSA Reports Clearance Officer; Paperwork Reduction Project; 1 Choke Cherry Road, 7th Floor Rockville, Maryland 20857.

An agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0222 with an expiration date of 05-31-2013.

How the Synar report helps the Center for Substance Abuse Prevention

In accordance with the tobacco regulations, States are required to provide detailed information on progress made in enforcing youth tobacco access laws (FFY 2011 Compliance Progress) and future plans to ensure compliance with the Synar requirements to reduce youth tobacco access rates (FFY 2012 Intended Use Plan). These data are required by 42 U.S.C. 300x-26 and will be used by the Secretary to evaluate State compliance with the statute. Part of the mission of the Center for Substance Abuse Prevention (CSAP) is to assist States[1] by supporting Synar activities and providing technical assistance helpful in determining the type of enforcement measures and control strategies that are most effective. This information is helpful to CSAP in improving technical assistance resources and expertise on enforcement efforts and tobacco control program support activities, including State Synar Program support services, through an enhanced technical assistance program involving conferences and workshops, development of training materials and guidance documents, and onsite technical assistance consultation.

How the Synar report can help States

The information gathered for the Synar report can help States describe and analyze substate needs for program enhancements. These data can also be used to report to the State legislature and other State and local organizations on progress made to date in enforcing youth tobacco access laws when aggregated statistical data from State Synar reports can demonstrate to the Secretary the national progress in reducing youth tobacco access problems. This information will also provide Congress with a better understanding of State progress in implementing Synar, including State difficulties and successes in enforcing retailer compliance with youth tobacco access laws.

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[1]The term "State" is used to refer to all the States and territories required to comply with Synar as part of the Substance Abuse Prevention and Treatment Block Grant Program requirements (42 U.S.C. 300x-64 and 45 C.F.R. 96.121).

Getting assistance in completing the Synar report

If you have questions about programmatic issues, you may call CSAP's Division of State Programs at (240) 276-2413 and ask for your respective State Project Officer, or contact your State Project Officer directly by telephone or email using the directory provided in the FY 2012 Uniform Application, Appendix A. If you have questions about fiscal or grants management issues, you may call the Grants Management Officer, Office of Program Services, Division of Grants Management, at (240) 276-1422.

Where and when to submit the Synar report

The Annual Synar Report (ASR) must be received by SAMHSA no later than December 31, 2012. The ASR must be submitted in the **approved OMB report format.** Use of the approved format will avoid delays in the review and approval process. The chief executive officer (or an authorized designee) of the applicant organization must sign page 1 of the ASR certifying that the State has complied with all reporting requirements.

The State must upload one copy of the ASR using the online WebBGAS (Block Grant Application System). In addition, the following items must be uploaded to WebBGAS:

- FFY 2012 Synar Survey Results: States that use the Synar Survey Estimation System (SSES) must upload one copy of SSES Tables 1–5 (in Excel) to WebBGAS. States that do not use SSES must upload one copy of ASR Forms 1, 4, and 5, and Forms 2 and 3, if applicable, (in Excel) to WebBGAS.

- Synar Inspection Form: States must upload one blank copy of the inspection form used to record the result of each Synar inspection.

- Synar Inspection Protocol: States must upload a copy of the protocol used to train inspection teams on conducting and reporting the results of the Synar inspections.

Each State SSA Director has been emailed a login ID and password to log onto the Synar section of the WebBGAS site.

Additionally, the State must submit one signed original of the report (including the signed Funding Agreements/Certifications), as well as one additional copy of the signed Funding Agreements/Certifications, to the Grants Management Officer at the address below:

Grants Management Officer
Office of Program Services
Division of Grants Management
Substance Abuse and Mental Health Services Administration

Regular Mail: **Overnight Mail:**

1 Choke Cherry Road, Rm.7-1091   1 Choke Cherry Road, Rm.7-1091
Rockville, Maryland 20857   Rockville, Maryland 20850

FFY 2012: FUNDING AGREEMENTS/CERTIFICATIONS

The following form must be signed by the Chief Executive Officer or an authorized designee and submitted with this application. Documentation authorizing a designee must be attached to the application.

PUBLIC HEALTH SERVICES ACT AND SYNAR AMENDMENT
42 U.S.C. 300x-26 requires each State to submit an annual report of its progress in meeting the requirements of the Synar Amendment and its implementing regulation (45 C.F.R. 96.130) to the Secretary of the Department of Health and Human Services. By signing below, the chief executive officer (or an authorized designee) of the applicant organization certifies that the State has complied with these reporting requirements and the certifications as set forth below.
SYNAR SURVEY SAMPLING METHODOLOGY
The State certifies that the Synar survey sampling methodology on file with the Center for Substance Abuse Prevention and submitted with the Annual Synar Report for FFY 2012 is up-to-date and approved by the Center for Substance Abuse Prevention.
SYNAR SURVEY INSPECTION PROTOCOL
The State certifies that the Synar Survey Inspection Protocol on file with the Center for Substance Abuse Prevention and submitted with the Annual Synar Report for FFY 2012 is up-to-date and approved by the Center for Substance Abuse Prevention.
State: Arizona
Name of Chief Executive Officer or Designee: Will Humble
Signature of CEO or Designee:
Title: Director, Arizona Department of Health Services   **Date Signed:**
If signed by a designee, a copy of the designation must be attached.

SECTION I: FFY 2011 (Compliance Progress)

YOUTH ACCESS LAWS, ACTIVITIES, AND ENFORCEMENT

42 U.S.C. 300x-26 requires the States to report information regarding the sale/distribution of tobacco products to individuals under age 18.

1. **Please indicate any changes or additions to the State tobacco statute(s) relating to youth access since the last reporting year. If any changes were made to the State law(s) since the last reporting year, please attach a photocopy of the law to the hard copy of the ASR and also upload a copy of the State law to WebBGAS.** *(see 42 U.S.C. 300x-26).*

    a. **Has there been a change in the *minimum sale age* for tobacco products?**

    ☐ **Yes** ☒ **No**

    *If **Yes**, current minimum age:* ☐ 19 ☐ 20 ☐ 21

    b. **Have there been any changes in State law that impact the State's *protocol for conducting Synar inspections?*** ☐ **Yes** ☒ **No**

    *If **Yes**, indicate change. (Check all that apply.)*

    ☐ Changed to require that law enforcement conduct inspections of tobacco outlets
    ☐ Changed to make it illegal for youth to possess, purchase or receive tobacco
    ☐ Changed to require ID to purchase tobacco
    ☐ Other change(s) *(Please describe.)* _____

    c. **Have there been any changes in the law concerning *vending machines?***

    ☐ **Yes** ☒ **No**

    *If **Yes**, indicate change. (Check all that apply.)*

    ☐ Total ban enacted
    ☐ Banned from location(s) accessible to youth
    ☐ Locking device or supervision required
    ☐ Other change(s) *(Please describe.)* _____

    d. **Have there been any changes in State law that impact the following?**

    Licensing of tobacco vendors ☐ **Yes** ☒ **No**
    Penalties for sales to minors ☐ **Yes** ☒ **No**

2. **Describe how the Annual Synar Report** *(see 45 C.F.R. 96.130(e))* **and the State Plan** *(see 42 U.S.C. 300x-51)* **were made public within the State prior to submission of the ASR.** *(Check all that apply.)*

    ☒ Placed on file for public review
    ☒ Posted on a State agency Web site *(Please provide exact Web address.)*
    http://www.azdhs.gov/bhs/grants/sapt.htm

☐ Notice published in a newspaper or newsletter

☐ Public hearing

☐ Announced in a news release, a press conference, or discussed in a media interview

☐ Distributed for review as part of the SAPT Block Grant application process

☐ Distributed through the public library system

☐ Published in an annual register

☐ Other *(Please describe.)* _____

3. **Identify the following agency or agencies** *(see 42 U.S.C. 300x-26 and 45 C.F.R. 96.130).*

   a. **The State agency(ies)** *designated by the Governor for oversight of the Synar requirements:*

   Arizona Department of Health Services, Division of Behavioral Health Services

   Has this changed since last year's Annual Synar Report? ☐ **Yes** ☒ **No**

   b. **The State agency(ies)** *responsible for conducting random, unannounced Synar inspections:*

   Arizona Department of Health Services, Division of Behavioral Health Services

   Has this changed since last year's Annual Synar Report? ☐ **Yes** ☒ **No**

   c. **The State agency(ies)** *responsible for enforcing youth tobacco access law(s):*

   Arizona Attorney General's Office

   Has this changed since last year's Annual Synar Report? ☐ **Yes** ☒ **No**

4. **Identify the State agency responsible for tobacco prevention activities (the agency that receives the Centers for Disease Control and Prevention's National Tobacco Control Program funding).**

   Arizona Department of Health Services, Bureau of Tobacco and Chronic Diseases

   Has the responsible agency changed since last year's Annual Synar Report?

   ☐ **Yes** ☒ **No**

   a. **Describe the coordination and collaboration that occur between the agency responsible for tobacco prevention and the agency responsible for oversight of the Synar requirements.** *(Check all that apply.)* **The two agencies**

   ☒ Are the same

   ☐ Have a formal written memorandum of agreement

   ☒ Have an informal partnership

   ☒ Conduct joint planning activities

   ☐ Combine resources

   ☒ Have other collaborative arrangement(s) *(Please describe.)* *All partners meet on a quarterly basis.*

5. **Please answer the following questions regarding the State's activities to enforce the youth access to tobacco law(s) in FFY 2011** *(see 42 U.S.C. 300x-26 and 45 C.F.R. 96.130(e)).*

a. **Which one of the following describes the enforcement of youth access to tobacco laws carried out in your State?** *(Check one category only.)*

☒ Enforcement is conducted exclusively by local law enforcement agencies.

☐ Enforcement is conducted exclusively by State agency(ies).

☐ Enforcement is conducted by both local *and* State agencies.

b. **The following items concern penalties imposed for violations of youth access to tobacco laws by <u>LOCAL AND/OR STATE LAW ENFORCEMENT AGENCIES</u>. Please fill in the number requested. If State law does not allow for an item, please mark "NA" (not applicable). If a response for an item is unknown, please mark "UNK." The chart must be filled in completely.**

PENALTY	OWNERS	CLERKS	TOTAL
Number of <u>citations issued</u>	N/A	146	146
Number of <u>fines assessed</u>	N/A	UNK	UNK
Number of <u>permits/licenses suspended</u>	N/A		N/A
Number of <u>permits/licenses revoked</u>	N/A		N/A
Other *(Please describe.)* *It is at the discretion of the jurisdiction to determine punishment for an offence. Said punishment could be community service etc.*	N/A	UNK	UNK

c. **Which one of the following best describes the level of enforcement of youth access to tobacco laws carried out in your State?** *(Check one category only.)*

☐ Enforcement is conducted only at those outlets randomly selected for the Synar survey.

☐ Enforcement is conducted only at a subset of outlets not randomly selected for the Synar survey.

☒ Enforcement is conducted at a combination of outlets randomly selected for the Synar survey and outlets not randomly selected for the Synar survey.

d. **Did every tobacco outlet in the State receive at least one enforcement compliance check in the last year?**

☐ Yes

☒ No

e. **What additional activities are conducted in your State to support enforcement and compliance with State tobacco access law(s)?** *(Check all that apply.)*

☒ Merchant education and/or training

☐ Incentives for merchants who are in compliance (e.g., nonenforcement compliance checks in which compliant retailers are given positive reinforcement and noncompliant retailers are warned about youth access laws)

☐ Community education regarding youth access laws

☐ Media use to publicize compliance inspection results

☐ Community mobilization to increase support for retailer compliance with youth access laws

☐ Other activities *(Please list.)* _____

Briefly describe all checked activities:

> Merchant education and training is conducted at the local level by community tobacco prevention coalitions.

f. Are citations or warnings issued to retailers or clerks who sell tobacco to minors for inspections that are part of the Synar survey? ☒ **Yes** ☐ **No**

If "Yes" to 5f, please describe the State's procedure for minimizing risk of bias to the survey results from retailers alerting each other to the presence of the survey teams:

> The Arizona Department of Health Services (ADHS), which oversees the Synar program, is also collaborating with the FDA funded enforcement program. The ADHS Office of Environmental Health hired 2 FDA inspectors and a program manager to conduct enforcement. FDA inspectors conduct all enforcement inspections. The Division of Behavioral Health Services, which oversees implementation of Synar, will provide youth inspectors for enforcement, training, and support in selection of retailers. The Division of Behavioral Health Services will maintain the list of retailers for Synar, while the FDA enforcement program will maintain their own list of retailers.

g. Please describe the relationship between the State's Synar program and the Food and Drug Administration-funded enforcement program:

> The Arizona Department or Health Services works collaboratively with the FDA-funded enforcement program. The FDA enforcement program and Synar program utilize the same prevention agencies which have been previously used for Synar only. These prevention agencies maintain separate records and documents for both the Synar and FDA programs. The collaborative effort is such that Synar undercover buys do not include the FDA undercover buys. Synar and FDA Inspection teams are to remain separate.

SYNAR SURVEY METHODS AND RESULTS

The following questions pertain to the survey methodology and results of the Synar survey used by the State to meet the requirements of the Synar Regulation in FFY 2011 (see 42 U.S.C. 300x-26 and 45 C.F.R. 96.130).

6. Has the sampling methodology changed from the previous year? ☐ **Yes** ☒ **No**

The State is required to have an approved up-to-date description of the Synar sampling methodology on file with CSAP. Please submit a copy of your Synar Survey Sampling

Methodology (Appendix B). If the sampling methodology changed from the previous reporting year, these changes must be reflected in the methodology submitted.

7. **Please answer the following questions regarding the State's annual random, unannounced inspections of tobacco outlets** *(see 45 C.F.R. 96.130(d)(2)).*

   a. **Did the State use the optional Synar Survey Estimation System (SSES) to analyze the Synar survey data?** ☒ **Yes** ☐ **No**

      *If **Yes**, attach SSES summary tables 1, 2, 3, and 4 to the hard copy of the ASR and upload a copy of SSES tables 1–5 (in Excel) to WebBGAS. Then go to Question 8. If **No**, continue to Question 7b.*

   b. **Report the weighted and unweighted Retailer Violation Rate (RVR) estimates, the standard error, accuracy rate (number of eligible outlets divided by the total number of sampled outlets), and completion rate (number of eligible outlets inspected divided by the total number of eligible outlets).**

      Unweighted RVR _____

      Weighted RVR _____

      Standard error (s.e.) of the (weighted) RVR _____

      Fill in the blanks to calculate the <u>right limit</u> of the right-sided 95% confidence interval.

_____	+	(1.645	×	_____)	=	_____
RVR Estimate	**plus**	**(1.645**	**times**	**Standard Error)**	**equals**	**Right Limit**

      Accuracy rate _____

      Completion rate _____

   c. **Fill out Form 1 in Appendix A (Forms 1–5).** *(Required regardless of the sample design.)*

   d. **How were the (weighted) RVR estimate and its standard error obtained?** *(Check the one that applies.)*

      ☐ Form 2 (Optional) in Appendix A (Forms 1–5) *(Attach completed Form 2.)*
      ☐ Other *(Please specify. Provide formulas and calculations or attach and explain the program code and output with description of all variable names.)*

   e. **If stratification was used, did any strata in the sample contain only one outlet or cluster this year?** ☐ **Yes** ☐ **No** ☐ **No stratification**

      *If **Yes**, explain how this situation was dealt with in variance estimation.*

f. Was a cluster sample design used? ☐ **Yes** ☐ **No**

*If **Yes,** fill out and attach Form 3 in Appendix A (Forms 1–5), and answer the following question.*

*If **No,** go to Question 7g.*

Were any certainty primary sampling units selected this year? ☐ **Yes** ☐ **No**

*If **Yes,** explain how the certainty clusters were dealt with in variance estimation.*

g. **Report the following outlet sample sizes for the Synar survey.**

	Sample Size
Effective sample size (sample size needed to meet the SAMHSA precision requirement assuming simple random sampling)	
Target sample size (the product of the effective sample size and the design effect)	
Original sample size (inflated sample size of the target sample to counter the sample attrition due to ineligibility and noncompletion)	
Eligible sample size (number of outlets found to be eligible in the sample)	
Final sample size (number of eligible outlets in the sample for which an inspection was completed)	

h. **Fill out Form 4 in Appendix A (Forms 1–5).**

8. **Did the State's Synar survey use a list frame?** ☐ **Yes** ☒ **No**

    *If **Yes,** answer the following questions about its coverage.*

    a. **The calendar year of the latest frame coverage study:** <u>use list-assisted area frame</u>
        <u>– coverage study not required</u>

    b. **Percent coverage from the latest frame coverage study:** _____

    c. **Was a new study conducted in this reporting period?** ☐Yes ☐ No

        *If **Yes,** please complete Appendix D (List Sampling Frame Coverage Study) and submit it with the Annual Synar Report.*

    d. **The calendar year of the next coverage study planned:** _____

9. **Has the Synar survey inspection protocol changed from the previous year?**

    ☐ **Yes** ☒ **No**

    The State is required to have an approved up-to-date description of the Synar inspection protocol on file with CSAP. Please submit a copy of your Synar Survey Inspection Protocol (Appendix C). If the inspection protocol changed from the previous year, these changes must be reflected in the protocol submitted.

    a. **Provide the inspection period: From** <u>07/01/2011</u> **to** <u>08/01/2011</u>
        MM/DD/YY MM/DD/YY

    b. **Provide the number of youth inspectors used in the current inspection year:**

        <u>11</u>

        NOTE: If the State uses SSES, please ensure that the number reported in 9b matches that reported in SSES Table 4, or explain any difference.

    c. **Fill out and attach Form 5 in Appendix A (Forms 1–5).** *(Not required if the State*

used SSES to analyze the Synar survey data.)

SECTION II: FFY 2012 (Intended Use):

Public law 42 U.S.C. 300x-26 of the Public Health Service Act and 45 C.F.R. 96.130 (e) (4, 5) require that the States provide information on future plans to ensure compliance with the Synar requirements to reduce youth tobacco access.

1. **In the upcoming year, does the State anticipate any changes in:**

    Synar sampling methodology   ☐ **Yes**   ☒ **No**

    Synar inspection protocol   ☐ **Yes**   ☒ **No**

    If changes are made in either the Synar sampling methodology or the Synar inspection protocol, the State is required to obtain approval from CSAP prior to implementation of the change and file an updated Synar Survey Sampling Methodology (Appendix B) or an updated Synar Survey Inspection Protocol (Appendix C), as appropriate.

2. **Please describe the State's plans to maintain and/or reduce the target rate for Synar inspections to be completed in FFY 2012. Include a brief description of plans for law enforcement efforts to enforce youth tobacco access laws, activities that support law enforcement efforts to enforce youth tobacco access laws, and any anticipated changes in youth tobacco access legislation or regulation in the State.**

    Arizona plans to maintain the target rate for FFY 2012 through continued implementation of its CSAP approved protocols and sampling design. Arizona's plan involves consistent adherence to previous year's methods in sampling methodology, inspection protocol, law enforcement activities, merchant education, community education, media use, and community mobilization. As of July 1, 2011 a statute was put in place that says youth who falsely provide an ID that says he or she is 18 years of age to purchase tobacco products will be subject to a fine of not more than $500. No sampling methodology changes are planned.

    The Department of Revenue Retail List will continue to be updated and will likely continue to be problematic. The list suffers from too many establishments identified that do not sell tobacco products and fails to include many businesses that do sell tobacco.

3. **Describe any challenges the State faces in complying with the Synar regulation.** *(Check all that apply.)*

    ☒ Limited resources for law enforcement of youth access laws

    ☐ Limited resources for activities to support enforcement and compliance with youth tobacco access laws

    ☒ Limitations in the State youth tobacco access laws

    ☐ Limited public support for enforcement of youth tobacco access laws

    ☒ Limitations on completeness/accuracy of list of tobacco outlets

    ☐ Limited expertise in survey methodology

    ☐ Laws/regulations limiting the use of minors in tobacco inspections

    ☐ Difficulties recruiting youth inspectors

☐ Geographic, demographic, and logistical considerations in conducting inspections

☐ Cultural factors (e.g., language barriers, young people purchasing for their elders)

☐ Issues regarding sources of tobacco under tribal jurisdiction

☐ Other challenges *(Please list.)*_____

Briefly describe all checked challenges and propose a plan for each, or indicate the State's need for technical assistance related to each relevant challenge.

Limited Resources for Law Enforcement of Youth Tobacco Laws

To date, although the Arizona Attorney Generals office conducts the majority of tobacco enforcement inspections, actual citations may only be issued by local law enforcement entities and the newly funded FDA enforcement program. Due to the economy many law enforcement agencies in Arizona have had to decrease workforce resulting in fewer officers to participate in tobacco enforcement activities. This barrier was resolved when Arizona received an FDA enforcement grant.

Limitations in youth tobacco access laws

Youth tobacco access laws do not provide for fines for the actual vendors, only the clerk. The fine for the clerk can be up to $300. Only in the City of Tucson can a tobacco licence be revoked for sales to minors, so penalties for sales are minimal. To resolve this issue, the Division of Behavioral Health has in 2009 and 2010, submitted recommendations to ammend Arizona Revised Statutes.

Limitations on completeness/accuracy of list of tobacco outlets

Due to the economic recession in Arizona, there is a large and rapid turn over in businesses which sell tobacco. The actual number of businesses selling tobacco decreased by nearly 16% between 2009 and 2010.

APPENDIX A: FORMS 1–5

FORM 1 (Required for all States not using the Synar Survey Estimation System (SSES) to analyze the Synar Survey data)

Complete Form 1 to report sampling frame and sample information and to calculate the unweighted retailer violation rate (RVR) using results from the current year's Synar survey inspections.

Instructions for Completing Form 1: In the top right-hand corner of the form, provide the State name and reporting Federal fiscal year (FFY 2012). Provide the remaining information by stratum if stratification was used. Make copies of the form if additional rows are needed to list all the strata.

Column 1:   *If stratification was used*:

      1(a) Sequentially number each row.
      1(b) Write in the name of each stratum. All strata in the State must be listed.

      If no stratification was used:

      1(a) Leave blank.
      1(b) Write "State" in the first row (indicates that the whole State is a single stratum).

      Note for unstratified samples: For Columns 2–5, wherever the instruction refers to "each stratum," report the specified information for the State as a whole.

Column 2:   2(a) Report the number of over-the-counter (OTC) outlets in the sampling frame in each stratum.
      2(b) Report the number of vending machine (VM) outlets in the sampling frame in each stratum.
      2(c) Report the combined total of OTC and VM outlets in the sampling frame in each stratum.

Column 3:   3(a) Report the estimated number of eligible OTC outlets in the OTC outlet population in each stratum.
      3(b) Report the estimated number of eligible VM outlets in the VM outlet population in each stratum.
      3(c) Report the combined total estimated number of eligible OTC and VM outlets in the total outlet population in each stratum.

      The estimates for Column 3 can be obtained from the Synar survey sample as the weighted sum of eligible outlets by outlet type.

Column 4:   4(a) Report the number of eligible OTC outlets for which an inspection was completed, for each stratum.
      4(b) Report the numbers of eligible VM outlets for which an inspection was completed, for each stratum.
      4(c) Report the combined total of eligible OTC and VM outlets for which an inspection was completed, for each stratum.

Column 5:   5(a) Report the number of OTC outlets found in violation of the law as a result of completed inspections, for each stratum.
      5(b) Report the number of VM outlets found in violation of the law as a result of completed inspections, for each stratum.
      5(c) Report the combined total of OTC and VM outlets found in violation of the law as a result of completed inspections, for each stratum.

Totals: For each subcolumn (a–c) in Columns 2–5, provide totals for the State as a whole in the last row of the table. These numbers will be the sum of the numbers in each row for the respective column.

FORM 1 (Required for all States not using the Synar Survey Estimation System [SSES] to analyze the Synar Survey data.)

Summary of Synar Inspection Results by Stratum													
State: _____													
FFY: 2012													
(1)		(2)			(3)			(4)			(5)		
STRATUM		NUMBER OF OUTLETS IN SAMPLING FRAME			ESTIMATED NUMBER OF ELIGIBLE OUTLETS IN POPULATION			NUMBER OF OUTLETS INSPECTED			NO. OF OUTLETS FOUND IN VIOLATION DURING INSPECTIONS		
(a) Row #	(b) Stratum Name	(a) Over-the-Counter (OTC)	(b) Vending Machines (VM)	(c) Total Outlets (2a+2b)	(a) Over-the-Counter (OTC)	(b) Vending Machines (VM)	(c) Total Outlets (3a+3b)	(a) Over-the-Counter (OTC)	(b) Vending Machines (VM)	(c) Total Outlets (4a+4b)	(a) Over-the-Counter (OTC)	(b) Vending Machines (VM)	(c) Total Outlets (5a+5b)

RECORD COLUMN TOTALS ON LAST LINE (LAST PAGE ONLY IF MULTIPLE PAGES ARE NEEDED).

FORM 2 (Optional)
Appropriate for stratified simple or systematic random sampling designs.

Complete Form 2 to calculate the weighted RVR. This table (in Excel form) is designed to calculate the weighted RVR for stratified simple or systematic random sampling designs, accounting for ineligible outlets and noncomplete inspections encountered during the annual Synar survey.

Instructions for Completing Form 2: In the top right-hand corner of the form, provide the State name and reporting Federal fiscal year (FFY 2012).

Column 1:   Write in the name of each stratum into which the sample was divided. These should match the strata reported in Column 1(b) of Form 1.

Column 2:   Report the number of outlets in the sampling frame in each stratum. These numbers should match the numbers reported for the respective strata in Column 2(c) of Form 1.

Column 3:   Report the original sample size (the number of outlets originally selected, *including* substitutes or replacements) for each stratum.

Column 4:   Report the number of sample outlets in each stratum that were found to be eligible during the inspections. Note that this number must be less than or equal to the number reported in Column 3 for the respective strata.

Column 5:   Report the number of eligible outlets in each stratum for which an inspection was completed. Note that this number must be less than or equal to the number reported in Column 4. These numbers should match the numbers reported in Column 4(c) of Form 1 for the respective strata.

Column 6:   Report the number of eligible outlets inspected in each stratum that were found in violation. These numbers should match the numbers reported in Column 5(c) of Form 1 for the stratum.

Column 7:   Form 2 (in Excel form) will automatically calculate the stratum RVR for each stratum in this column. This is calculated by dividing the number of inspected eligible outlets found in violation (Column 6) by the number of inspected eligible outlets (Column 5). The State unweighted RVR will be shown in the Total row of Column 7.

Column 8:   Form 2 (in Excel form) will automatically calculate the estimated number of eligible outlets in the population for each stratum. This calculation is made by multiplying the number of outlets in the sampling frame (Column 2) times the number of eligible outlets (Column 4) divided by the original sample size (Column 3). Note that these numbers will be less than or equal to the numbers in Column 2.

Column 9:   Form 2 (in Excel form) will automatically calculate the relative stratum weight by dividing the estimated number of eligible outlets in the population for each stratum in Column 8 by the Total of the values in Column 8.

Column 10:   Form 2 (in Excel form) will automatically calculate each stratum's contribution to the State weighted RVR by multiplying the stratum RVR (Column 7) by the relative stratum weight (Column 9). The weighted RVR for the State will be shown in the Total row of Column 10.

Column 11:   Form 2 (in Excel form) automatically calculates the standard error of each stratum's RVR (Column 7). The standard error for the State weighted RVR will be shown in the Total row of Column 11.

TOTAL: For Columns 2–6, Form 2 (in Excel form) provides totals for the State as a whole in the last row of the table. For Columns 7–11, it calculates the respective statistic for the State as a whole.

FORM 2 (Optional) Appropriate for stratified simple or systematic random sampling designs.

— Calculation of Weighted Retailer Violation Rate										
									State:_____	
									FFY: 2012 _____	
(1) Stratum Name	(2) N Number of Outlets in Sampling Frame	(3) n Original Sample Size	(4) n1 Number of Sample Outlets Found Eligible	(5) n2 Number of Outlets Inspected	(6) x Number of Outlets Found in Violation	(7) p=x/n2 Stratum Retailer Violation Rate	(8) N'=N(n1/n) Estimated Number of Eligible Outlets in Population	(9) w=N'/Total Column 8 Relative Stratum Weight	(10) pw Stratum Contribution to State Weighted RVR	(11) s.e. Standard Error of Stratum RVR
Total										

N - number of outlets in sampling frame
n - original sample size (number of outlets in the original sample)
n1 - number of sample outlets that were found to be eligible
n2 - number of eligible outlets that were inspected
x - number of inspected outlets that were found in violation
p - stratum retailer violation rate (p=x/n2)
N' - estimated number of eligible outlets in population (N'=N*n1/n)
w - relative stratum weight (w=N'/Total Column 8)
pw - stratum contribution to the weighted RVR
s.e. - standard error of the stratum RVR

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FORM 3 (Required when a cluster design is used for all States not using the Synar Survey Estimation System [SSES] to analyze the Synar survey data.)

Complete Form 3 to report information about primary sampling units when a cluster design was used for the Synar survey.

Instructions for Completing Form 3: In the top right-hand corner of the form, provide the State name and reporting Federal fiscal year (FFY 2012).

Provide information by stratum if stratification was used. Make copies of the form if additional rows are needed to list all the strata.

Column 1: Sequentially number each row.

Column 2: *If stratification was used*: Write in the name of stratum. All strata in the State must be listed.

If no stratification was used: Write "State" in the first row to indicate that the whole State constitutes a single stratum.

Column 3: Report the number of primary sampling units (PSUs) (i.e., first-stage clusters) created for each stratum.

Column 4: Report the number of PSUs selected in the original sample for each stratum.

Column 5: Report the number of PSUs in the final sample for each stratum.

TOTALS: For Columns 3–5, provide totals for the State as a whole in the last row of the table.

	Summary of Clusters Created and Sampled			
			State:	
			FFY: 2012	
(1) Row #	(2) Stratum Name	(3) Number of PSUs Created	(4) Number of PSUs Selected	(5) Number of PSUs in the Final Sample
	Total			

FORM 4 (Required for all States not using the Synar Survey Estimation System [SSES] to analyze the Synar Survey data)

Complete Form 4 to provide detailed tallies of ineligible sample outlets by reasons for ineligibility and detailed tallies of eligible sample outlets with noncomplete inspections by reasons for noncompletion.

Instructions for Completing Form 4: In the top right-hand corner of the form, provide the State name and reporting Federal fiscal year (FFY 2012).

Column 1(a): Enter the number of sample outlets found ineligible for inspection by reason for ineligibility. Provide the total number of ineligible outlets in the row marked "Total."

Column 2(a): Enter the number of eligible sample outlets with noncomplete inspections by reason for noncompletion. Provide the total number of eligible outlets with noncomplete inspections in the row marked "Total."

Inspection Tallies by Reason of Ineligibility or Noncompletion				
		State:		
		FFY: 2012		
(1) INELIGIBLE			(2) ELIGIBLE	
Reason for Ineligibility	**(a) Counts**	**Reason for Noncompletion**		**(a) Counts**
Out of business		In operation but closed at time of visit		
Does not sell tobacco products		Unsafe to access		
Inaccessible by youth		Presence of police		
Private club or private residence		Youth inspector knows salesperson		
Temporary closure		Moved to new location		
Unlocatable		Drive-thru only/youth inspector has no driver's license		
Wholesale only/Carton sale only		Tobacco out of stock		
Vending machine broken		Ran out of time		
Duplicate		Other noncompletion reason(s) *(Describe.)*		
Other ineligibility reason(s) *(Describe.)*				
Total		**Total**		

FORM 5 (Required for all States not using the Synar Survey Estimation System [SSES] to analyze the Synar survey data)

Complete Form 5 to show the distribution of outlet inspection results by age and gender of the youth inspectors.

Instructions for Completing Form 5: In the top right-hand corner of the form, provide the State name and reporting Federal fiscal year (FFY 2012).

Column 1:   Enter the number of attempted buys by youth inspector age and gender.

Column 2:   Enter the number of successful buys by youth inspector age and gender.

If the inspectors are age eligible but the gender of the inspector is unknown, include those inspections in the "Other" row. Calculate subtotals for males and females in rows marked "Male Subtotal" and "Female Subtotal." Sum subtotals for Male, Female, and Other and record in the bottom row marked "Total." Verify that that the total of attempted buys and successful buys equals the total for Column 4(c) and Column 5(c), respectively, on Form 1. If the totals do not match, please explain any discrepancies.

Synar Survey Inspector Characteristics		
State:		
FFY: 2012		
	(1) Attempted Buys	(2) Successful Buys
Male		
15 years		
16 years		
17 years		
18 years		
Male Subtotal		
Female		
15 years		
16 years		
17 years		
18 years		
Female Subtotal		
Other		
Total		

APPENDIXES B & C: FORMS

<u>Instructions</u>

Appendix B (Sampling Design) and Appendix C (Inspection Protocol) are to reflect the State's CSAP-approved sampling design and inspection protocol. These appendixes, therefore, should generally describe the design and protocol and, with the exception of Question #10 of Appendix B, are not to be modified with year-specific information. Please note that any changes to either appendix must receive CSAP's advance, written approval. To facilitate the State's completion of this section, simply cut and paste the previously approved sampling design (Appendix B) and inspection protocol (Appendix C).

APPENDIX B: SYNAR SURVEY SAMPLING METHODOLOGY

State: Arizona

FFY: 2012

1. **What type of sampling frame is used?**

   ☐ List frame *(Go to Question 2.)*

   ☐ Area frame *(Go to Question 3.)*

   ☒ List-assisted area frame *(Go to Question 2.)*

2. **List all sources of the list frame. Indicate the type of source from the list below. Provide a brief description of the frame source. Explain how the lists are updated (method), including how new outlets are identified and added to the frame. In addition, explain how often the lists are updated (cycle).** *(After completing this question, go to Question 4.)*

   Use the corresponding number to indicate **Type of Source** *in the table below*.

   1 – Statewide commercial business list   **4** – Statewide retail license/permit list
   2 – Local commercial business list   **5** – Statewide liquor license/permit list
   3 – Statewide tobacco license/permit list   **6** – Other

Name of Frame Source	Type of Source	Description	Updating Method and Cycle
2010 Frame	1	This is the list used for the 2010 sample	Annually (ADHS)
New outlets from last year's sample	6	ADHS conducts a comprehensive sample of 33% of the all clusters each year including the inspections which were not in the frame.	Annually (ADHS)
New outlets from the Arizona Department of Revenue	6	Inspection list used to inspect outlets for use of the tobacco stamp	Annually (ADOR)
City of Tucson Tobacco License List	2	This is a list of vendors which are licensed to sell tobacco in Tucson.	Annually (City of Tucson)

3. **If an area frame is used, describe how area sampling units are defined and formed.**

   a. **Is any area left out in the formation of the area frame?** ☒ **Yes**   ☐ **No**

   *If **Yes,** what percentage of the State's population is not covered by the area frame?*
   Native American and Military Reservations not included; Approximately 2.5%

4. **Federal regulation requires that vending machines be inspected as part of the Synar survey. Are vending machines included in the Synar survey?** ☐ **Yes**   ☒ **No**

   *If **No,** please indicate the reason they are not included in the Synar survey.*

   ☐ State law bans vending machines.

   ☒ State law bans vending machines from locations accessible to youth.

$\boxtimes$ State has SAMHSA approval to exempt vending machines from the survey.

$\square$ Other *(Please describe.)* _____

5. **Which category below best describes the sample design?** *(Check only one.)*

$\square$ **Census** *(STOP HERE: Appendix B is complete.)*

Unstratified statewide sample:

$\square$ Simple random sample *(Go to Question 9.)*

$\square$ Systematic random sample *(Go to Question 6.)*

$\boxtimes$ Single-stage cluster sample *(Go to Question 8.)*

$\square$ Multistage cluster sample *(Go to Question 8.)*

Stratified sample:

$\square$ Simple random sample *(Go to Question 7.)*

$\square$ Systematic random sample *(Go to Question 6.)*

$\square$ Single-stage cluster sample *(Go to Question 7.)*

$\square$ Multistage cluster sample *(Go to Question 7.)*

$\square$ **Other** *(Please describe and go to Question 9.)* _____

6. **Describe the systematic sampling methods.** *(After completing Question 6, go to Question 7 if stratification is used. Otherwise go to Question 9.)*

7. **Provide the following information about stratification.**

    a. **Provide a full description of the strata that are created.**

    b. **Is clustering used within the stratified sample?**

    $\square$ **Yes** *(Go to Question 8.)*

    $\square$ **No** *(Go to Question 9.)*

8. **Provide the following information about clustering.**

    a. **Provide a full description of how clusters are formed.** *(If multistage clusters are used, give definitions of clusters at each stage.)*

    Contiguous zip codes are used to create 128 cluster areas in Arizona, each with approximately 43 outlets based on the list frame. The cluster is defined by its zip codes. A map of Arizona's zip codes combined with the number of outlets in each zip code are used to make decisions on which zip codes are combined to form a cluster.

    b. **Specify the sampling method (simple random, systematic, or probability proportional to size sampling) for each stage of sampling and describe how the method(s) is (are) implemented.**

The method used was simple random sample of clusters (single stage cluster sample). All outlets are inspected within each cluster including all new outlets found in the cluster area.

Generate N (unique) random numbers and assign one to each cluster.

Order the clusters in acsending order of the random numbers. The resulting list is a randomly sorted list of clusters from which clusters are accepted until the first 50 clusters are drawn.

The first 20 clusters in the sample are released to the fieldwork contractors. The remaining clusters are released one at a time, as needed, in the same order as they are selected.

Each cluster entered for inspection must be comprehensively canvassed for all tobacco outlets, which must then be inspected along with the pre-listed outlets. DBHS staff participate as ride along observers to ensure conformance with the comprehensive approach.

9. **Provide the formulas for determining the effective, target, and original outlet sample sizes.**

Effective sample size (ESS) = p(1-p) / Var(p), where p = .2 or previous year's RVR and Var(p) = (0.03/1.645)2 = .0003326, which is the maximum variance to meet SAMHSA precision requirement of 3 percent of margin of error for right-sided 95% confidence interval for RVR.

Target Sample Size (TSS) = (ESS)*(DE), where DE is the design effect coming from the previous year's survey.

Original Outlet Sample Size = (TSS)/Accuracy Rate, where the accuracy rate is obtained from the previous year's survey.

10. **Provide the following information about sample size calculations for the current FFY Synar survey.**

    a. **If the State uses the sample size formulas embedded in the Synar Survey Estimation System (SSES) Sample Size Calculator, please provide the following information:**

    Inputs for Effective Sample Size:
    RVR:
    Frame Size:

    Input for Target Sample Size:
    Design Effect:

    Inputs for Original Sample Size:
    Safety Margin:
    Accuracy (Eligibility) Rate:
    Completion Rate:

b. If the State does not use the sample size formulas embedded in the SSES Sample Size Calculator, please provide all inputs required to calculate the effective, target, and original sample sizes as indicated in Question 9.

APPENDIX C: SYNAR SURVEY INSPECTION PROTOCOL

State: Arizona

FFY: 2012

Note: Upload to WebBGAS a copy of the Synar inspection form under the heading "Synar Inspection Form" and a copy of the protocol used to train inspection teams on conducting and reporting the results of the Synar inspections under the heading "Synar Inspection Protocol."

1. **How does the State Synar survey protocol address the following?**

   a. **Consummated buy attempts?**

   ☒ Required   ☐ Not permitted
   ☐ Permitted under specified circumstances   ☐ Not specified in protocol

   b. **Youth inspectors to carry ID?**

   ☐ Required   ☒ Not permitted
   ☐ Permitted under specified circumstances   ☐ Not specified in protocol

   c. **Adult inspectors to enter the outlet?**

   ☐ Required   ☐ Not permitted
   ☒ Permitted under specified circumstances   ☐ Not specified in protocol

   d. **Youth inspectors to be compensated?**

   ☒ Required   ☐ Not permitted
   ☐ Permitted under specified circumstances   ☐ Not specified in protocol

2. **Identify the agency(ies) or entity(ies) that actually conduct the random, unannounced Synar inspections of tobacco outlets.** *(Check all that apply.)*

   ☐ Law enforcement agency(ies)
   ☐ State or local government agency(ies) other than law enforcement
   ☒ Private contractor(s)
   ☐ Other

   List the agency name(s): **Pima Prevention Partnership and Community Bridges**

3. **Are Synar inspections combined with law enforcement efforts (i.e., do law enforcement representatives issue warnings or citations to retailers found in violation of the law at the time of the inspection?)?**

   ☐ Always   ☐ Usually   ☐ Sometimes   ☐ Rarely   ☒ Never

4. **Describe the methods used to recruit, select, and train youth inspectors and adult supervisors.**

Two Arizona prevention providers with experience in tobacco inspections and working with youth are used to conduct compliance inspections.

Each provider is responsible for recruiting between 4 and 10 16-year-old youth from their prevention programs to conduct inspections.   The ethnic composition of the youth typically reflects the ethnic composition of Arizona youth. Age testing is completed for the youth who participate in the study. Supporting documents are collected from all youth inspectors and include birth certificates, age appearance tests, permission slips, current photos, and photo identifications.   In every case a parent provides active consent for youth to participate in the project. Youth also sign an active consent form stating that they are willing to participate in the project. Youth are paid for participation in the inspections. There is no reward or penalty for making purchases. No youth is permitted to miss school to conduct inspections.

Adults are recruited from the identified prevention providers as chaperones. Chaperones are responsible for driving the vehicle, navigation, maintenance of youth inspector safety, taking care of youth inspector needs for food and breaks, and for accurate completion of paperwork. Chaperones are encouraged to have a second adult ride with them during inspections to navigate and/or complete documentation.

All providers including adult chaperones and youth inspectors are required to participate in an interactive group training held before inspections commence. Using a standardized curriculum, training objectives are designed to help inspection teams understand the Federal SYNAR requirements and inspection protocols.

Training commences with introductions, a review of the agenda and articulation of expectations for the training. Responsibilities of youth inspectors, adult inspectors, and the Department are reviewed in the training. Purchase protocols are trained in depth. Training is reinforced with a series of role-plays in which youth inspectors' practice entering stores and attempting to make tobacco inspection purchases.

Additional training topics include safety and supervision of youth inspectors, maintaining professional boundaries with youth inspectors, and making inspections fun. Department staff provide guidelines to contractors including schedule inspections for no more than eight hours in a day, providing lunch for inspection teams, and appropriate use of work breaks as needed. Finally, the training covers logistical issues such as the number of inspections, locations, and projected dates of inspections. Adult escorts participate in an administrative meeting in which payment for services delivered is discussed as well as procedures for documenting, collecting and turning in inspection forms.

ADHS staff members conduct field monitoring of the inspection teams for approximately 10% of the field time. ADHS staff members provide feedback, answer questions, and verify adherence to field protocols during monitoring. Additionally, providers communicate directly with DBHS during the inspections regarding questions that arise.

5. **Are there specific legal or procedural requirements instituted by the State to address the issue of youth inspectors' immunity when conducting inspections?**

   a. **Legal**   ☐ **Yes** ☒ **No** *(If Yes, please describe.)*

b. **Procedural** ☒ **Yes** ☐ **No** *(If Yes, please describe.)*

> The Arizona Department of Health Services sends a letter to county attorneys across the state informing them that SYNAR inspections will be taking place and inviting them to contact ADHS should they have questions or concerns

6. **Are there specific legal or procedural requirements instituted by the State to address the issue of the safety of youth inspectors during all aspects of the Synar inspection process?**

    a. **Legal** ☐ **Yes** ☒ **No** *(If Yes, please describe.)*

>

    b. **Procedural** ☒ **Yes** ☐ **No** *(If Yes, please describe.)*

> Inspection teams including youth inspectors and adult supervisors receive training in safety procedures prior to commencement of inspections. Teams are instructed to not inspect any business that they perceive to be unsafe. Businesses not inspected for these reasons are documented. The protocol also allows adult supervisors to inconspicuously enter a business before and separate from the youth inspector to assess safety.

7. **Are there any other legal or procedural requirements the State has regarding how inspections are to be conducted (e.g., age of youth inspector, time of inspections, training that must occur)?**

    a. **Legal** ☐ **Yes** ☒ **No** *(If Yes, please describe.)*

>

    b. **Procedural** ☒ **Yes** ☐ **No** *(If Yes, please describe.)*

> All youth inspectors must be age 16. The gender balance of selected youth is 50% female and 50% male. Exceptions to the gender balance take place when unexpected events arise, such as a resignation of a youth inspector. Inspections occur at a variety of times during the day and days of the week including weekends. All youth inspectors are required to complete training provided by ADHS. ADHS staff perform field monitoring on approximately half of inspections.

APPENDIX D: LIST SAMPLING FRAME COVERAGE STUDY

(LIST FRAME ONLY)

State: Arizona

FFY: _____

1. **Calendar year of the coverage study:** _____

2. a. **Unweighted percent coverage found:** _____%
   b. **Weighted percent coverage found:** _____%
   c. **Number of outlets found through canvassing:** _____
   d. **Number of outlets matched on the list frame:** _____

3. a. **Describe how areas were defined.** *(e.g., census tracts, counties, etc.)*

   [   ]

   b. **Were any areas of the State excluded from sampling?** ☐ **Yes** ☐ **No**

   *If **Yes,** please explain.*

   [   ]

4. **Please answer the following questions about the selection of canvassing areas.**

   a. **Which category below best describes the sample design?** *(Check only one.)*

   ☐ **Census** *(Go to Question 6.)*

   Unstratified Statewide sample:
   ☐ Simple random sample *(Respond to Part b.)*
   ☐ Systematic random sample *(Respond to Part b.)*
   ☐ Single-stage cluster sample *(Respond to Parts b and d.)*
   ☐ Multistage cluster sample *(Respond to Parts b and d.)*

   Stratified sample:
   ☐ Simple random sample *(Respond to Parts b and c.)*
   ☐ Systematic random sample *(Respond to Parts b and c.)*
   ☐ Single-stage cluster sample *(Respond to Parts b, c, and d.)*
   ☐ Multistage cluster sample *(Respond to Parts b, c, and d.)*
   ☐ **Other** *(Please describe and respond to Part b.)* _____

   b. **Describe the sampling methods.**

   [   ]

c. Provide a full description of the strata that were created.

> [ ]

d. Provide a full description of how clusters were formed.

> [ ]

5. **Were borders of the selected areas clearly identified at the time of canvassing?**

   ☐ **Yes** ☐ **No**

6. **Were all sampled areas visited by canvassing teams?**

   ☐ **Yes** *(Go to Question 7.)* ☐ **No** *(Respond to Parts a and b.)*

   a. **Was the subset of areas randomly chosen?**

      ☐ **Yes** ☐ **No**

   b. **Describe how the subsample of visited areas was drawn. Include the number of areas sampled and the number of areas canvassed.**

   > [ ]

7. **Were field observers provided with a detailed map of the canvassing areas?**

   ☐ **Yes** ☐ **No**

   If No, describe the canvassing instructions given to the field observers.

   > [ ]

8. **Were field observers instructed to find all outlets in the assigned area?**

   ☐ **Yes** ☐ **No**

   If No, respond to Question 9.
   If Yes, describe any instructions given to the field observers to ensure the entire area was canvassed, then go to Question 10.

   > [ ]

9. **If a full canvassing was not conducted:**

   a. **How many predetermined outlets were to be observed in each area?** _____

   b. **What were the starting points for each area?** _____

   c. **Were these starting points randomly chosen?** ☐ **Yes** ☐ **No**

   d. **Describe the selection of the starting points.**

   > [ ]

e. Please describe the canvassing instructions given to the field observers, including predetermined routes.

10. Describe the process field observers used to determine if an outlet sold tobacco.

11. Please provide the State's definition of "matches" or "mismatches" to the Synar sampling frame? (i.e., address, business name, business license number, etc).

12. Provide the calculation of the weighted percent coverage (if applicable).